

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5700

4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Eight Months
 Hospital, institution, or street address where death occurred:
807 Maryland Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 807 Maryland Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Earnest Van Adams

3. (b) Social Security Number

376-09-2269

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Olive Rachel Edwards Adams
 6.(c) If alive, give age 55 years
 7. Birth date of deceased (mo., day, yr.) May 28- 1890
 8. AGE: Years 58 Months 0 Days 21 If less than one day
hrs.min.

9. Birthplace Connellsville Pa.
 (Town, county, and state)
 10. Usual occupation laborer
 11. Industry or business General Box Co
 12. Name William H. Adams
 13. Birthplace Brownsville Pa.
 14. Maiden name Minnie Crawford
 15. Birthplace Brownsville Pa.

16. Informant Mrs. Earnest V. Adams (wife)
 Address Cumberland Md.
 17. Burial Date thereof 6/22/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Hill Grove Cemetery
Connellsville, Pa.
 Location

18. Funeral director Charles McCormick
 Address Connellsville, Pa

19. June 21, 1948 W.R. Taubert, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1948 3:30 AM

I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... to 19.....
 and that I last saw him alive June 19 1948

Immediate cause of death Massive pulmonary hemorrhage DURATION about 3 minutes
bronchogenic carcinoma of
the upper left hilum

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
Deputy Medical Examiner - Allegany Co.

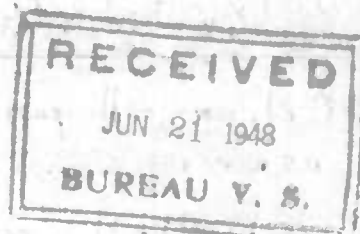
23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
 M. D. or other
Cumberland Md. Date signed 6-19-48
 Address

RECEIVED

JUN 29 1948

BUREAU V. S.

7 17 44
1948-~~8~~-~~14~~
1871-7-29
76-10-15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. P. E. Berry

CERTIFICATE OF DEATH

Reg. Dist. No.

6 5702

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 72 years
 Hospital, institution, or street address where death occurred:
113 Jamisson St.
 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 152 Wood St
 (If rural, give LOCATION)
 2.(a) If veteran, name war - - - - -

3. (a) FULL NAME

ELIZABETH ANN BECK

3. (b) Social Security Number

- - - - -

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Frederick H. Beck
 6.(c) If alive, give age - - years
 7. Birth date of deceased (mo., day, yr.) February 29, 1876
 8. AGE: Years 72 Months 3 Days 13 It less than one day - hrs. - min.

9. Birthplace Luke, Allegany, Maryland
 (Town, county, and state)
 10. Usual occupation Domestic
 11. Industry or business Own home
 12. Name John R. Jones
 13. Birthplace Wales
 14. Maiden name James Parcell
 15. Birthplace Wales

16. Informant William Beck
 Address Westernport, Maryland
 17. Burial Date thereof May June 11, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Philos Cemetery
 Location Westernport, Maryland
 18. Funeral director Ellsworth S. Boal
 Address Westernport, Maryland

19. June 10 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 48 at 6:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 48, to June 8 19 48
 and that I last saw her alive on June 8 19 48

Immediate cause of death Carcinoma of stomach DURATION 1 yr.

Due to Intestinal obstruction 2 mo.

Due to - - - - -

Other conditions Depression 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations - - - - -Date of op. - - - - -Autopsy results - - - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide - - - - - Date of - - - - -

Where did injury occur? - - - - - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) - - - - -

Means of injury - - - - - Injured at work? - - - - -

23. SIGNATURE P. E. Berry M.D. M. D. or other - - - - -

Address Piedmont W.D. Date signed 6/9/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5703

1. PLACE OF DEATH:

County AlleghenyCity or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 68-3-13

Hospital, institution, or street address where death occurred:

Allegheny HospitalInd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)Street No. 131 S. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Henry Joseph Bety

3.(b) Social Security Number

717-107-815

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced6.(b) Name of husband or wife Blana Easter6.(c) If alive, give age 68 years

7. Birth date of

deceased (mo., day, yr.) Feb 27 1880

8. AGE:

Years

Months

Days

If less than one day

68313

hrs.

min.

9. Birthplace

Cumtland Ind.

(Town, county, and state)

10. Usual occupation

Baker

11. Industry or business

MOTHER FATHER

12. Name

Henry Bety

13. Birthplace

Germany

14. Maiden name

Elizabeth Proffiter

15. Birthplace

Germany

16. Informant

Mrs. Blana Jones

Address

Washington D. C.

17. Burial

St Peter & Pauls Bm

Date thereof

June 12 48

(Burial, cremation, or removal) Which?

Cemetery or crematory

Cumtland Ind.

Location

Cumtland Ind.

18. Funeral director

Edwin Stein Inc.

Address

Cumtland Ind.

19. June 11 1948

W. H. Tautz, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1948 at

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 6 48 to June 10 48and that I last saw him alive on June 10 1948

Immediate cause of death

Causes of the stomach

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Causes of the stomachDate of op. 6-1-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Tautz, M.D.

M. D. or other

Address 58 Greene St. Date signed 6-11-48

RECEIVED
JUN 15 1948
BUREAU V. S.

Hand

Within corporate limits

DR. VAN ORMER *Simons*

KIGHTS FUNERAL HOME

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *5704*

1. PLACE OF DEATH:

County *ALLEGANY*City or town *CUMBERLAND*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *47 DAYS*Hospital, institution, or street address where death occurred:
*MEMORIAL HOSPITAL*How long in hospital or institution? *47 DAYS*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MARYLAND* County *ALLEGANY*City or town *CUMBERLAND*
(If outside city or town limits, write RURAL and give nearest town)Street No. *211 CHARLES ST.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. JENNIE BIRMINGHAM

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

*FEMALE WHITE WIDOWED*6.(b) Name of husband or wife *JOHN BIRMINGHAM*

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *MARCH 3, 1871*8. AGE: Years Months Days If less than one day
77 3 14 hrs. min.9. Birthplace *Maryland*
(Town, county, and state)10. Usual occupation *HOUSE WIFE*

11. Industry or business

12. Name *MATHEW FLANNIGAN*13. Birthplace *IRELAND*14. Maiden name *ELIZABETH HAGGERTY*15. Birthplace *ENGLAND*16. Informant *MEMORIAL HOSPITAL*Address *MEMORIAL AVE., CITY*17. *Burial* Date thereof *6/19/48*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *St. Patricks Cemetery*Location *Cumberland, Md.*18. Funeral director *William H. Kight*Address *Cumberland, Md.*19. *June 18, 1948* *Wd. Tautz, M.D.*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *JUNE 17, 1948* 12:20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 12, 1948 to *June 17, 1948*and that I last saw him alive on *June 17, 1948*

Immediate cause of death

*Cachexia*Due to *Squamous cell carcinoma of rectum*Due to *generalized metastasis*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *George M. Simon* M. D. or otherAddress *Memorial Hospital* Date signed *6/17/48*

RECEIVED

JUN 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Allegany
City or town Mr Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Cemetery Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Allegany
City or town Mr Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cemetery Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Katherine Brailer

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Single

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1893

8. AGE: Years Months Days If less than one day
54 7 8 hrs. min.

9. Birthplace Mr Savage, Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

12. Name Augustine Brailer

13. Birthplace Mr Savage md

14. Maiden name Mary A. Leddebury

15. Birthplace md

16. Informant Joseph Brailer

Address Mr Savage md

17. Burial Date thereof June 9, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Pat Cem.

Location Mr Savage md

18. Funeral director Louis Storn Luc

Address Cumberland md

19. June 8 19 48 Vernice K. Terrell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19 48 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 48 to June 6 19 48

and that I last saw him alive on June 3 19 48

Immediate cause of death Coronary Artery

Myocardial infarction

Due to Myocardial

Due to Diabetes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Alan G. Murray

M. D. or other

Address Cumberland md Date signed June 7/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Murray.

RECEIVED

JUN 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

838

5706

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs
Hospital, institution, or street address where death occurred:
129 Bedford St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 129 Bedford St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Mrs Mary Elizabeth Bratt

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Arthur Wm Bratt
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) March 27 1869

8. AGE: Years 29 Months 2 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Baltimore, Ind.
(Town, county, and state)

10. Usual occupation Housework
11. Industry or business at home

12. Name Wm Bratt Tracy
13. Birthplace Baltimore, Ind.

14. Maiden name Mary E. Tracey
15. Birthplace Baltimore, Ind.

16. Informant Mrs. Carl Murray
Address 129 Bedford St. Cumberland, Ind.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof June 6, 1948
(month) (day) (year)
Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Ind.
18. Funeral director John J. Hager
Address Cumberland, Ind.

19. June 5 19 48 W.R. Fantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 48 at 7:13 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 19 48 to June 3 19 48
and that I last saw him/her alive on June 3 19 48

Immediate cause of death Cerebral Thrombosis
DURATION 4 days

Due to Cerebral sclerosis 1037

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE A.H. Gleason, M.D.
Address 156 W. 10th St. Cumberland, Ind. Date signed 6/5/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5707

8

1. PLACE OF DEATH:

County Allegany
 City or town Lonaconing
 (outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 59 years & 20 days
 Hospital, institution, or street address where death occurred:
Quince Street
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Lonaconing
 (if outside city or town limits, write RURAL and give nearest town)
 Street No. Quince Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war Gas

3. (a) FULL NAME

James Barber Brown

3. (b) Social Security Number

216-05-5864

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Plorence Kiddy
 7. Birth date of deceased (mo., day, yr.) Sept. 15, 1888
 6. (c) If alive, give age 59 years
 8. AGE: Years 59 Months 8 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Lonaconing, Allegany Co., Md.

(Town, county, and state)

10. Usual occupation Cemetery Sexton11. Industry or business Oak Hill Cemetery, Lonaconing, Md.12. Name William Brown13. Birthplace Lonaconing, Md.14. Maiden name Spargaut Reed15. Birthplace Lonaconing, Md.16. Informant Mrs. Jas. BrownAddress Lonaconing, Md.17. Burial Date thereof June 7, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill CemeteryLocation Lonaconing, Md.18. Funeral director Dr. EichhornAddress Lonaconing, Md.19. June 7, 1948 Annette McNeal

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1948 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4, 1948 to June 5, 1948and that I last saw him alive on June 4, 1948Immediate cause of death Chronic Myocarditis

DURATION

2 wks

Due to

Due to

Other conditions Generalized Anasarca

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Westernport, Md.Date signed 6/17/48

RECEIVED

JUN 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5708

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. VA County PRESTON
City or town BRUCETON MILLS
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

MASTER EARL BRYTE, Jr

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced INFANT

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) MARCH 12, 1948 6.(c) If alive, give age _____ years

8. AGE: Years _____ Months 3 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace W. VA
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name EARL BRYTE

13. Birthplace W. VA

14. Maiden name LOVA EVERLY

15. Birthplace W. VA

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE.

17. Burial Date thereof July 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brandouville

Location Brandouville, W. Va.

18. Funeral director E. G. Tarned

Address Brandouville, W. Va.

19. June 30, 1948 Registrar W. R. Tautz, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 30 19 48 at 12:20 A

21. CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 19 48 to June 30 19 48
and that I last saw him alive on June 30 19 48

Immediate cause of death Long Absence left home
Empyema extreme
Due to Pneumonia, Bronchial

Due to _____
Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Same as above Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE George M. Simon M. D. or other _____
Address Memorial Hospital Date signed 6/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 110 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Katherine Maus Buckler

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Paul T. Buckler

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1884 18748. AGE: Years 73 Months 9 Days 8 It less than one day
hrs. min.9. Birthplace Cumberland, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Matthais Maus13. Birthplace Alsace Lorraine14. Maiden name Mary A. Zapf15. Birthplace Cumberland, Md.16. Informant Mrs. Paulvera RatiganAddress 110 Bedford St. Cumberland, Md.17. Burial Date thereof June 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory S.S. Peter & Paul Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. June 13, 48 W.R. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1948, 3:40A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6, 1948 to June 10, 1948
and that I last saw him alive on June 9, 1948Immediate cause of death Mipocordia InfarctionDue to Coronary Occlusion DURATION 3 daysDue to Arteriosclerosis & HypertensionOther conditions Heart disease

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. R. Trautz, M.D.Address 110 Bedford St. Cumberland, Md. M.D. or otherDate signed 6/11/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1947
1884
63

RECEIVED

JUN 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5710

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegheny
 City or town Brookings, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all her life in Ohio
 Hospital, institution, or street address where death occurred:
Memorial Hospital, Brookings, Md.
 How long in hospital or institution? 21 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ohio County Jefferson
 City or town Mr. Pleasant
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Edna Burriss

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Edmund Burriss

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug 11-1870

8. AGE: Years 77 Months 9 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Mr. Pleasant Ohio
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas P. Gorsuch

13. Birthplace Unknown

14. Maiden name Mary McMaster

15. Birthplace Unknown

16. Informant (Son) Myron Burriss

Address Mr. Pleasant Ohio

17. Burial Date thereof 6-29-48
 (Burial, cremation, or removal. Which?) (year)

Cemetery or crematory Highland Cemetery

Location 24th Pleasant, Ohio

18. Funeral director James Hager

Address Brookings, Md.

19. 6-27 19 48 Mrs. B. O. Price
 (Date rec'd by registrar) acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 19 48 at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him DEAD June 27 19 48

Immediate cause of death Coronary thrombosis and shock DURATION _____

Due to Fracture of left femur + fracture tibia + fibula right leg lower third

Due to Automobile accident 6/24/48

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto accident Date of 6/26/48

Where did injury occur? Brookings Allegheny (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) East Main - Street 88

Means of injury Crushed by auto

Medical Examiner Allegany Co

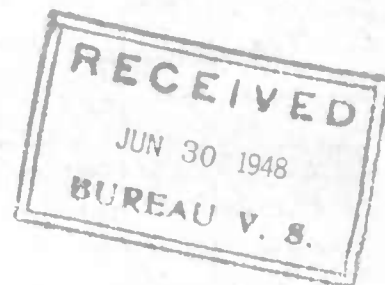
23. SIGNATURE H. V. Deming M.D. M. D. or other _____

Address Cumberland Md Date signed 6-27-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5711

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
1013 Bedford Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1013 Bedford Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Susan Casteel

3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Shadwick Casteel
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 18, 1870
 8. AGE: Years 78 Months 2 Days 13 It less than one day _____ hrs. _____ min.

9. Birthplace Centreville, Bedford Co. Pennsylvania
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Nave
 13. Birthplace Bedford Co. Pennsylvania
 14. Maiden name Amy Hendrickson
 15. Birthplace Bedford Co. Pennsylvania

16. Informant Mrs. Anna Kimmel
1013 Bedford Street, Cumberland, Maryland

17. Burial Date thereof June 3, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Luthern Cemetery
 Location Centreville, Pa.

18. Funeral director William H. Kight
 Address Cumberland, Maryland

19. June 3, 1948 W.R. Frank, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st 1948 at 10:20
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29th 1948 until June 1st 1948
 and that I last saw her alive on May 31st 1948
 Immediate cause of death

Septic Myocarditis 1 wk
Chronic Endocarditis several
Hypertension years
 Other conditions several
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE W.R. Frank, M.D. M. D. or other
 Address Bedford Co. Pa. Date signed 6-2-48

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5712

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
305 South Allegheny Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 South Allegheny Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Samuel L. Cessna

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elsie Anderson Cessna
6. (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Oct. 9th. 1871
8. AGE: Years 76 Yrs. Months 8 mos Days 11 das. If less than one day hrs. min.

9. Birthplace Odderain Twp., Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation Farmer - Retired

11. Industry or business

12. Name William Cessna

13. Birthplace Bedford Co., Pa.

14. Maiden name Rachel Rose

15. Birthplace Bedford Co., Pa.

16. Informant Bedford Co., Pa.

Address Elsie A. Cessna, Chesapeake

17. Burial Date thereof June 23rd. 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Memorial Park Bedford, Pa.

Location Mc C. Pate - Son.

18. Funeral director

Address # 203 So. Juliana St., Bedford, Pa.

19. June 23. 1948 W.R. Brantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1948 at 7 9 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19, 1948 to 19. 48

and that I last saw him alive on June 19, 1948

Immediate cause of death Cerebral Hemorrhage

DURATION 24 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

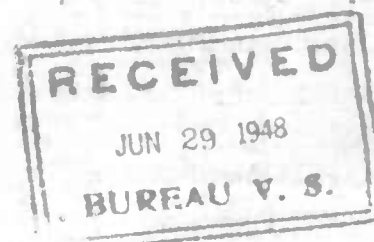
23. SIGNATURE D. J. Rees, M.D. M. D. or other

Address 404 Decatur St. Date signed 6/22/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5713

93d

1. PLACE OF DEATH:

County **Allegany**
 City or town **Cumberland**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **76 Years**
 Hospital, institution, or street address where death occurred:
Sylvan Retreat
 How long in hospital or institution? **30 Days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County **Allegany**
 City or town **Cumberland**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **332 Baltimore Ave**
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Augusta Chandler

3. (b) Social Security Number

None

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Widow	
6. (b) Name of husband or wife Cornelius C Chandler			
7. Birth date of deceased (mo., day, yr.) August 25 1872			
8. AGE: 75	Years 75	Months 9	Days 14
If less than one day hrs. min.			
9. Birthplace Germany (Town, county, and state)			
10. Usual occupation House			
11. Industry or business "			
MOTHER	12. Name Frederick Yeager		
	13. Birthplace Germany		
	14. Maiden name Unknown		
FATHER	15. Birthplace "		

16. Informant Mrs Charles B. Connors	
Address 481 Goethe St, Cumberland, Md	
17. Burial (Burial, cremation, or removal, Which?)	Date thereof 6/12/48 (month) (day) (year)
Cemetery or crematory St Lukes Cemetery	
Location Cumberland, Md.	
18. Funeral director William H. Kight	
Address Cumberland, Md.	
19. June 12 (Date rec'd by registrar)	48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1948	at 4-30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1948 to June 9 1948 and that I last saw him alive on June 7 1948	
Immediate cause of death myocardial failure	DURATION 30 days
Due to Chronic myocarditis & cardiac hypertrophy	8 yrs
Due to hypertensive vascular disease	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations	Date of op.
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	

22. VIOLENCE: If death was due to external causes, fill in the following:		
Accident, suicide, or homicide	Date of	
Where did injury occur?	(City or town)	(County) (State)
Injured at home, farm, industry, public place (where?)		
Means of injury	Injured at work?	
23. SIGNATURE Arthur F. Jones M.D. M. D. or other		
Address 110 S. Centre St.		Date signed 6-11-48

RECEIVED

JUN 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DB HODGES
XXXXXX

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5714

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County HardyCity or town MOOREFIELD
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

COBY, BABY BOY DIXON LEE

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) JUNE 17, 1948

8. AGE: Years _____ Months _____ Days _____ If less than one day
1 DAY _____ hrs. _____ min.

9. Birthplace MARYLAND, CUMBERLAND,
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name COBY, JOHN D.
13. Birthplace W.VA.

14. Maiden name KESSELL, GENEVIEVE C.
15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. BURIAL Date thereof June 19, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of interment SCOTT'S CEMETERY,
Location DURGON, W.VA.

18. Funeral director P. E. THRUSH
Address MOOREFIELD, W.VA.

19. June 19, 1948 W.D. Trouty, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 18, 1948 19 48 7:15 Pm

21. CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1948 to June 18, 1948
and that I last saw him alive on June 18, 1948

Immediate cause of death Pneumonia
DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

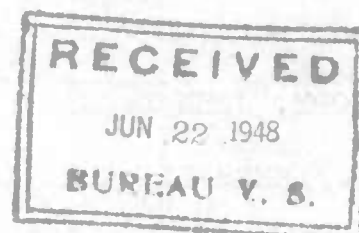
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W.D. Trouty, M.D. M. D. or other _____Address Cumberland, Md Date signed 6/19/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5715

131b

1. PLACE OF DEATH:

County AlleghenyCity or town Butterfield
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60-1-18Hospital, institution, or street address where death occurred: Allegheny HospitalHow long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Butterfield
(If outside city or town limits, write RURAL and give nearest town)Street No. 117 G. Walnut Place
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Margaret E Combs

3. (b) Social Security Number

None4. Sex Female5. Color or race Colored6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Ernest Combs

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 11 18888. AGE: Years 60 Months 1 Days 18 If less than one day

hrs. min.

9. Birthplace Butterfield Ind.
(Town, county, and state)10. Usual occupation House work

11. Industry or business

12. Name Daniel Bromery13. Birthplace Ind.14. Maiden name Francis Harper15. Birthplace Ind.16. Informant Mrs. Marion MatthewsAddress Butterfield17. Burial Date thereof June 30 '48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Butterfield18. Funeral director Louis Stein IncAddress Butterfield19. June 30 19 48 W.D. Fauch, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 48 at 12:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 19 48 to June 29 19 48and that I last saw him alive on June 28 19 48

Immediate cause of death

uremiaDue to chronic nephritis

Due to

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE L. Whips M.D.Address 59 Sierra St.Date signed 6-29-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5716

DR. BROADRUP

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....155 DAYS
 Hospital, institution, or street address where death occurred:
 MEMORIAL HOSPITAL
 How long in hospital or institution?.....155 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....9 E SECOND ST
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

HENRY J CONWAY

3. (b) Social Security Number

217-10-7603

4. Sex.....MALE 5. Color or race.....WHITE 6.(a) Single, married, widowed, or divorced.....SINGLE
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age.....years
 7. Birth date of deceased (mo., day, yr.).....JAN 8, 1877
 8. AGE: Years.....71 Months.....4 Days.....24 If less than one day.....hrs.....min.

9. Birthplace.....NEW YORK
 (Town, county, and state)
 10. Usual occupation.....RETIRED
 11. Industry or business.....

12. Name.....JAMES CONWAY
 13. Birthplace.....IRELAND
 14. Maiden name.....ELLEN GEARY
 15. Birthplace.....IRELAND

16. Informant.....MEMORIAL HOSPITAL
 Address.....MEMORIAL AVENUE

17. Date thereof.....June 5, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....St. Peter's & Paul's Cem.
 Location.....Cumberland, Md.

18. Funeral director.....Louis Stein, Inc.
 Address.....Cumberland, Md.

19. Date rec'd by registrar.....June 2, 1948
 Registrar.....W. L. Vautz, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH.....JUNE 2, 1948 at 9:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 December 30, 1948 to June 2, 1948
 and that I last saw him alive on June 2, 1948

Immediate cause of death

Chronic Myocarditis
 Due to Essential Hypertension
 Other conditions.....

DURATION

2 years
 5 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

Address.....Cumberland, Md.
 Date signed.....6-2-48

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

5717

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 70-1928

Hospital, institution, or street address where death occurred:

713 S. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 713 S. Mechanic St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

James Wesley Cook

3. (b) Social Security Number

712-14-1689

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Hermitta Erdeman

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 18 1876

8. AGE:

Years

Months

Days

If less than one day

71811

hrs.

min.

9. Birthplace

Newark, Ohio
(Town, county, and state)

10. Usual occupation

Traffic representative

11. Industry or business

R. R. Co Retired

12. Name

James A. Cook

13. Birthplace

Ind.

14. Maiden name

Annie Smith

15. Birthplace

Ind.

16. Informant

Mrs Russell J. Ponton

Address

Cumberland

17. Burial

Burial

Date thereof

July 1 48
(month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland

18. Funeral director

Louis Stein Inc

Address

Cumberland

19. June 30

19 45W. H. Taub, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 2919 48at 12:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1948to June 2919 48

and that I last saw him alive on

June 2619 48

Immediate cause of death

Carcinoma

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Bailey Hunter MD

M. D. or other

Address

Cumberland Md

Date signed

6/29/48

RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

5718

CERTIFICATE OF DEATH

Items 3(b), 12, 14, 15, 25, 10/30/48, 1/25/49, 1/25/49

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

964 Glenwood St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 964 Glenwood St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Vergie Cornelius

3. (b) Social Security Number

40-18-16-3947

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Wilbur Cornelius

7. Birth date of deceased (mo., day, yr.) May 26, 1896

8. AGE: Years 52 Months I Days I It less than one day hrs. min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)

10. Usual occupation Waitress

11. Industry or business

12. Name Charles S. Smith Miller

13. Birthplace Md.

14. Maiden name Grayson Mary Ann Garrison

15. Birthplace Virginia Md.

16. Informant Mrs. Virginia Mc Millin

Address 964 Glenwood St

17. Burial Date thereof June 30, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys

Location Cumberland, Md.

18. Funeral director James F. Scarpelli

Address 108 Virginia Ave

19. June 28, 48 W. D. Hantz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1948 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 5, 1948 to May 29, 1948

and that I last saw him alive on May 29, 1948

Immediate cause of death Myocardial Infarction

Other conditions Arteriosclerosis

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE W. D. Hantz M. D. or other None

Address None Date signed 6/28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5719

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 65 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. VA County GRANT
City or town GORMANIA W. VA
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

HIRAM B COTTRILL

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, or divorced SINGLE

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) DEC. 20, 1865

8. AGE: Years 82 Months 7 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Harrison County W. Va.
(Town, county, and state)

10. Usual occupation Coal operator

11. Industry or business _____

12. Name WILLIAM COTTRILL

13. Birthplace W. VA

14. Maiden name COFFMAN MARY JANE

15. Birthplace W. VA

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE

17. Burial Date thereof June 10, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium Copeland

Location Near Salem N. Va.

18. Funeral director H. E. Thrush and Son

Address Petersburg, W. Va.

19. June 10, 1948 W. H. Hantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 10, 1948 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-16-48 to 6-10-48

and that I last saw him alive on 6-9-48

Immediate cause of death _____ DURATION _____

Carcinoma of Prostate
Due to with multiple metastases

Due to _____

Other conditions Arteriosclerosis
myocardial degeneration
(Include pregnancy within 3 months of death)

Major findings of operations _____

as above Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Howard S. Tolson, M.D.

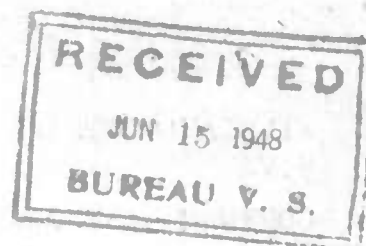
M. D. or other _____

Address Cumberland, Md. Date signed 6-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

53

5720

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town near Cumberland rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, institution, or street address where death occurred:
R. 7 S. # 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Allegany
City or town near Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. 7 S. # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Virgie Elizabeth Crabtree

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Willard Crabtree

7. Birth date of deceased (mo., day, yr.)

July 29, 1901

6. (c) If alive, give age

51 years

8. AGE:

Years 46 Months 10 Days 20 If less than one day
hrs. min.

9. Birthplace

Kifer, Allegany Co. Md.

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Andrew Robertson

13. Birthplace

Kifer, Md.

14. Maiden name

Martha Roby

15. Birthplace

Kifer, Md.

16. Informant

Paul Crabtree

Address

Rt #2 Cumberland Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

June 22, 1948

Cemetery or crematory

Wt Herman Methodist

Location

near Cumberland Md

18. Funeral director

John J. Hager

Address

Cumberland Md.

19. Date rec'd by registrar

June 22, 48 Wt. Frank, Md.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 19

19.

48 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to June 19, 1948

and that I last saw him alive on

June 17, 1948

Immediate cause of death

Cardiomegaly of aortic with generalized atherosclerosis

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James J. Johnson M.D.

Address

Cumberland Md.

M. D. or other

Date signed

6-20-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content of this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

A. B Schindler

RECEIVED

JUN 29 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 daysHospital, institution, or street address where death occurred:
Allegany County InfirmaryHow long in hospital or institution? 4 days

3. (a) FULL NAME

James Crosser4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Margaret Robertson6. (c) If alive, give age 5 years7. Birth date of deceased (mo., day, yr.) March 28, 18658. AGE: Years 83 Months 2 Days 16 It less than one day8. (c) If alive, give age 5 years9. Birthplace Larkhall, Scotland
(Town, county, and state)10. Usual occupation Missing11. Industry or business Pekin Mine, Lonaconing12. Name John Crosser13. Birthplace Scotland14. Maiden name Elizabeth Barr15. Birthplace Scotland16. Informant Henry CrosserAddress Lonaconing, Md.17. Burial, cremation, or removal. Which? Burial Date thereof June 17, 1948
(month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Lonaconing, Md.18. Funeral director M. E. EckhornAddress Lonaconing, Md.19. June 15, 1948 W. H. Trout, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Lozano mine
(If outside city or town limits, write RURAL and give nearest town)Street No. West main Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 19 48 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 19 48 to June 14 19 48and that I last saw him alive on June 12 19 48Immediate cause of death Myocardial infarctDue to Chronic myocarditisDue to Senility

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur J. Miles M.D.Address 1103 Centre St. Date signed 6-15-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF FINDINGS

INVESTIGATION OF ALLEGED VIOLATIONS OF THE

ANTITRUST LAWS

AND

CONSPIRACY TO VIOLATE THE ANTITRUST LAWS

AND

OBSTRUCTION OF JUSTICE

RECEIVED

JUN 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

5722

468

1. PLACE OF DEATH:

County... AlleghenyCity or town... Sparksburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 31 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Ind. County... AlleghenyCity or town... Sparksburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Joseph Cullen

3. (b) Social Security Number

214-01-3688

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

May Bryson

7. Birth date of deceased (mo., day, yr.)

July 2nd, 18866. (c) If alive, give age 60 years

8. AGE:

Years

Months

Days

If less than one day

611125

hrs.

min.

9. Birthplace

Charles, Allegheny

(Town, county, and state)

10. Usual occupation

11. Industry or business

Kelly Springfield

MOTHER FATHER

12. Name

John J. Cullen

13. Birthplace

West Virginia, Md.

14. Maiden name

Bridget Cullen

15. Birthplace

Scotland

16. Informant

Address

Mrs. Garrett CullenMain St. Sparksburg, Md.

17. (Burial, cremation, or removal, Which?)

Date thereof June 29, 1948
(month) (day) (year)

Cemetery or crematory

Location

St. Michael'sFrostburg, Md.

18. Funeral director

Address

Joseph WagnerFrostburg, Md.

19.

(Date rec'd by registrar)

19

4/2448Wm. R. O. Price
Acting

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 261948at 1034 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan1948

to

June 261948and that I last saw him alive on June 171948

Immediate cause of death

Calculation of stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. Lane MD

M. D. or other

Address

Frostburg, Md.

Date signed

6-28-48

RECEIVED
JUL 1 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5723

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

B&O.R.Ry. Power Plant, Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 325 Arch St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Herman B. Derlan

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Rose C. Triggeman7. Birth date of deceased (mo., day, yr.) Feb. 13-1892 6.(c) If alive, give age 61 years8. AGE: Years 56 Months 4 Days 1 if less than one day hrs. min.9. Birthplace Philadelphia, Pa.
(Town, county, and state)10. Usual occupation Engineer, in charge of Power11. Industry or business Plant at B&O.R.Ry.12. Name George Derlan13. Birthplace Vermont14. Maiden name Theresa Armbruster15. Birthplace Vermont16. Informant Walter DerlanAddress 323 Arch St.17. Burial Date thereof June 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland, Md.18. Funeral director John J. HoffAddress Cumberland, Md.19. June 15 48 W.R. Fautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH June 14 19 48 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to 19 48and that I last saw him Dead June 14 19 48Immediate cause of death Drowning & scaldingDURATION at onceDue to Accidentally fell in a 20ft. high tank, 50,000 gallons ofhot water, 170 degrees temperature.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-14-48Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Power Plant B&OMeans of injury Fell in tank of hot water. injured at work? yesDeputy Medical Examiner - Allegany Co.H.V. Deming M.D. H.V. Deming M.D.23. SIGNATURE H.V. Deming M.D. M. D. OfficerAddress Cumberland Md. Date signed 6-14-48

RECEIVED

JUN 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lottie Dye.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed.
 6.(b) Name of husband or wife Thornton C. Dye.
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Jan. 25, 1871.
 8. AGE: Years 77 Months 4 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Harpers Ferry, West Va.
 (Town, county, and state)
 10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name John William Cox
 13. Birthplace Harpers Ferry, West Va.
 MOTHER 14. Maiden name Sarah A.
 15. Birthplace Bunkerhill, Va.

16. Informant W. Harold Fiedlok
 Address Piedmont, W. Va.
 17. Burial Date thereof June 19, 1948.
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philos Cemetery,
 Location Westernport, Md.

18. Funeral director W. Harold Fiedlok
 Address Piedmont, W. Va.

19. June 19 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1948. 1948 at 10 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1948 to June 16 1948 and that I last saw him alive on June 16 1948
 Immediate cause of death Myocardial degeneration

DURATION 2 yrs
 Due to
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE James H. Volutek M. D. or other
 Address Piedmont, W. Va. Date signed 18 48

RECEIVED

JUN 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleganyCity or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Francis Farley

3. (b) Social Security Number

169-10-0766

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 26, 1881

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6686

hrs.

min.

9. Birthplace

Pittsburgh Allegheny Pa
(Town, county, and state)

10. Usual occupation

retired motor assembler

11. Industry or business

Westinghouse Electric

MOTHER

12. Name

James Farley

13. Birthplace

Maryland

14. Maiden name

Ellen McHugh

15. Birthplace

Ireland

16. Informant

Miss Lillian Feldman

Address

Eckhart Md.

17.

Burial
(Burial, cremation, or other? Which?)

Date thereof

June 5, 1948
(month) (day) (year)

Cemetery or crematory

St. Michael's Cemetery

Location

Frostburg Md.

18. Funeral director

J. R. Ours

Address

Frostburg Md.

19.

6-4

(Date rec'd by registrar)

19.

48 Mr. Bailey & Roe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 June 48 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 June 48 to 2 June 48and that I last saw him alive on 2 June 48Immediate cause of death Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none done

Date of op.

Autopsy results

none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John B. Davis

M. D.

Address Frostburg, Md. Date signed 3 June 48

RECEIVED

JUN 7 1948

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Wicomico
City or town Watersville Md
(if outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs
Hospital, institution, or street address where death occurred:
201 Smart St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WV County Allegheny
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 Elm St
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Oden Bucy Hazenbaker

3. (b) Social Security Number

4. Sex <i>Male</i>	5. Color or race <i>White</i>	6. (a) Single, married, widowed, or divorced <i>Married</i>	
6. (b) Name of husband or wife <i>Ida Fagerlund</i>		6. (c) If alive, give age <i>77 1/2</i> years	
7. Birth date of deceased (mo., day, yr.) <i>March 6 - 1871</i>			
8. AGE:	Years <i>77</i>	Months	Days
			If less than one dayhrs.min.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 25..... 1948, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....
, 1948, 1948

Immediate cause of death.....	DURATION.....
Angine pectoris.....	4 days.....

Due to coronary sclerosis

Due to.....

Other conditions Alcoholism years.

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

• **PHYSICIAN:** Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

County Medical Examiner - Allegany Co

H. V. Denning M.D.

23. SIGNATURE [Signature] M. D. or other 1548

9. Birthplace..... Westernport Md
(Town, county, and state)

10. Usual occupation... Shipyard Pulpworker

11. Industry or business Paper Mill

FATH 12. Name
13. Birthplace unknown

14. Maiden name

15. Birthplace Frederick, Maryland

16. Informant James Davis, MD

17 Burial Date thereof June 7, 1944

Philos Cemetery

Location Wentworth, Ind.

18. Funeral director Edward J. Bass.

Address West Winstar, Tex.

19 June 7 19 48 Register Registrar

MARGIN RESERVED FOR BINDING

VS A15-9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 38 years
 Hospital, institution, or street address where death occurred:
206 Cromwell St.
 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 206 Cromwell St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war - - - - -

3. (a) FULL NAME

ESSIE RAY FERGUSON

3. (b) Social Security Number

- - - - -

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife William L. Ferguson
 6.(c) If alive, give age 63 years
 7. Birth date of deceased (mo., day, yr.) February 13, 1887
 8. AGE: Years 61 Months 4 Days 5 It less than one day - hrs. - min.

9. Birthplace Piedmont, Mineral, W. Va.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own home

12. Name Jacob Hershberger
 13. Birthplace Maryland
 14. Maiden name Susan Hart
 15. Birthplace Piedmont, W. Va.

16. Informant William L. Ferguson
 Address Luke, Maryland

17. Burial Date thereof June 21, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philos Cemetery
 Location Westernport, Md.

18. Funeral director Ellsworth S. Boal
 Address Westernport, Maryland

19. June 21, 1948
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1948 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 1, 1948 to June 18, 1948
 and that I last saw h ex alive on June 18, 1948

Immediate cause of death Acute nephritis

Due to arteriosclerosis

Due to hypertension

Other conditions - - - - -

(Include pregnancy within 8 months of death)

Major findings of operations - - - - - Date of op. - - - - -

Autopsy results - - - - -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide - - - - - Date of - - - - -

Where did injury occur? - - - - - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) - - - - -

Means of injury - - - - - Injured at work? - - - - -

23. SIGNATURE P. Berry M.D.

Address Hot. Piedmont W. Va. Date signed 6/21/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1948

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. 1
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

John William Frankfort

3.(b) Social Security Number

705-09-6097

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Agatha Martin
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 8, 1874

8. AGE: Years 74 Months 1 Days 14 If less than one day hrs. min.

9. Birthplace Ursina, Pa.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business B.O. RR. Conductor

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Agatha Frankfort

Address Rt. 1, Cumberland, Md.

17. Burial Date thereof June 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Naper

Address Cumberland, Md.

19. June 25, 1948 W.D. Hantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1948 to June 22, 1948
and that I last saw him alive on June 22, 1948

Immediate cause of death
Heart failure
Heart block
DUE TO Embolus to right brachial
Artery

DUE TO Auricular fibrillation
Arteriosclerosis + Hypertension
Heart Disease
Other conditions Early Gangrene right upper 4 fingers
(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David G. Weisman, M.D.

Address Cumberland, Md. Date signed 6/25/48

RECEIVED

JUN 29 1948

BUREAU V. S.

DRC. L OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157g

5729

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY

City or town.....CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 1/2 HRS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 10 1/2 HRS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND County.....ALLEGANY

City or town.....Fruitburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 202 Spring Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MASTER DONALD FRIEND

3. (b) Social Security Number

None

4. Sex MASTER Color or race

6.(d) Single, married, widowed, or divorced

MALE

W

SINGLE

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

May 7, 1948

6.(c) If alive, give age.....years

8. AGE: Years Months Days If less than one day

1 MONTH

9. Birthplace.....Fruitburg, Maryland
(Town, county, and state)

10. Usual occupation.....none

11. Industry or business.....

12. Name ALBERT LEE FRIEND

13. Birthplace MARYLAND

14. Maiden name ALICE MARIE CRONE

15. Birthplace WEST VIRGINIA

16. Informant Albert Lee Friend

Address 202 Spring St. Fruitburg, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof June 11, 1948
(month) (day) (year)

Cemetery or crematory South Park Cemetery

Location Garrett County, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. June 11, 1948 C. R. Dantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th 1948 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 9th 1948 to June 9 1948
and that I last saw him alive on June 9th 1948

Immediate cause of death

Post operative shock

DURATION

5 hrs.

Due to

Operative Intestinal Obstruction

3 days

Due to

Probably Congenital

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. R. Owens M.D.

M. D. or other

Address Fruitburg, Md. Date signed 6-12-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

5730

93d

1. PLACE OF DEATH

County Allegany
 City or town Frankfort
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 88-7-28
 Hospital, institution, or street address where death occurred:
Douglas Avenue
 How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Frankfort
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Douglas Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war 1

3. (a) FULL NAME

Annie Thompson Fulton

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William Fulton

7. Birth date of deceased (mo., day, yr.) October 12, 1859

8. AGE: Years 88 Months 7 Days 28 If less than one day hrs. min.

9. Birthplace Lonaconing, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Cure home

12. Name Adam Thompson

13. Birthplace Scotland

14. Maiden name Ellen Spears

15. Birthplace Scotland

16. Informant Miss Chase Fulton

Address Lonaconing, Md.

17. Burial (burial, cremation, or removal, Which?) Burial Date thereof June 13, 1948
 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

18. Funeral director Wm. Eickhoff

Address Lonaconing, Md.

19. June 12 19 48 Janette M. Boal
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 / 10 19 48 at 2:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 48 to 6 / 10 19 48

and that I last saw her alive on 6 / 10 19 48

Immediate cause of death Congestive heart failure

Due to Hypertensive C-V disease

and atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

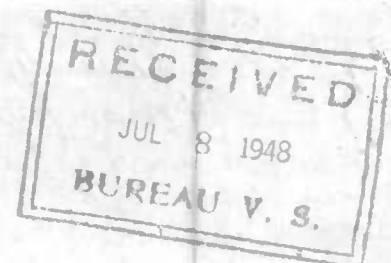
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Eugene Day, M.D.

Address Lonaconing, Md. Date signed 6/12/48



RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5731

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town LaVale, Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D.1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Alonzo Ellsworth Gephart

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

malewhitemarried6.(b) Name of husband or wife Carrie B. Valentine Gephart6.(c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) Oct. 22- 18788. AGE: Years Months Days If less than one day
69 8 0hrs.min.9. Birthplace Cumberland Md.
(Town, county, and state)10. Usual occupation retired-Cumberland Steel Co.

11. Industry or business

12. Name Harrison Gephart13. Birthplace Maryland14. Maiden name Hester Zimmerman15. Birthplace Maryland16. Informant Mrs. Carrie B. Gephart.Address St. #1 - LaVale, Md.17. Burial Date thereof June 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Killcrest.Location Cumberland, Md.18. Funeral director John J. Hafer.Address Cumberland.19. June 25 1948 W.R. Faubus, M.D.
(Date rec'd by registrar) Registrar

3.(b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 19 48 10:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him Dead June 23 19 48Immediate cause of death Epidural hematoma
left middle fossae

DURATION

17
daysDue to a fracture of the skull
left temporal region.Due to a fall on the street.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-5-48Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) in front of 157
N. Mechanic St.Means of Injury Fall Injured at work? no
Deputy Medical Examiner Allegany Co.23. SIGNATURE H.V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress Cumberland Md Date signed 6-23-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 29 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5732

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cambsland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 daysHospital, institution, or street address where death occurred: Allegheny HospitalHow long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Int Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. Railroad St.
(If rural, give LOCATION)

2.(a) if veteran, name war.....

3. (a) FULL NAME

Harvey Thomas Giffin

3. (b) Social Security Number

705-09-3743

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 48 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1 19 46 to June 12 19 48and that I last saw him alive on June 12 19 48

Immediate cause of death.....

DURATION

Cerebral Hemorrhage
Due to arterio sclerosis and
vascular hypertension
DUE TO.....
DUE TO.....1 week
Several
years.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Moseley M.D.Address Int Savage Rd Date signed June 13-48

FATHER

12. Name Emmanuel Giffin13. Birthplace Pa.

MOTHER

14. Maiden name Mary15. Birthplace Chapman16. Informant Bessie GiffinAddress Int Savage Rd17. Burial Date thereof June 15 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Cem.Location Int Savage Rd18. Funeral director Louis Stein Inc.Address Cambsland19. June 14 1948 W.R. Tautz, M.D.

(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5733

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland Md.How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 432 Columbia St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Paul Gormer

3. (b) Social Security Number

None4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Harriet Louis Seibert Gormer

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25-19108. AGE: Years 38 Months 4 Days 29 If less than one day
.....hrs.min.9. Birthplace Cumberland Md.
(Town, county, and state)10. Usual occupation City Fireman

11. Industry or business

FATHER 12. Name Samuel Gormer
13. Birthplace Cumberland Md.MOTHER 14. Maiden name Emma M. Heller
15. Birthplace Md.16. Informant Albert Gormer
Address 446 Walnut St17. Burial Date of death June 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem
Location Cumberland, Md.18. Funeral director John J. Hafer
Address Cumberland, Md.19. June 25, 48 W. H. Hauf Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1948 12.30 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....
and that I last saw him Dead June 24 1948Immediate cause of death Coronary occlusion
due to coronary sclerosis. DURATION 3 hrs.

Due to

Due to

Other conditions adhesive pericarditis &
chronic empyema
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. OtherAddress Cumberland Md. Date signed 6-24-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 29 1948

BUREAU V. S.

DR. W.F.WMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

5734

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. RT. #6, POTOMAC PARK,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES W. GROVE

3. (b) Social Security Number

217-10-5802

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

CORA S. BOWMAN

7. Birth date of deceased (mo., day, yr.)

JANUARY 24, 1884

6.(c) If alive, give age 58 years

8. AGE:

Years

Months

Days

It less than one day

64

5

6

hrs.

min.

9. Birthplace

PENNA.

(Town, county, and state)

10. Usual occupation

JANITOR

11. Industry or business

CELANESE CORP. OF AMERICA

FATHER

12. Name

WESLEY GROVE

13. Birthplace

PENNA

MOTHER

14. Maiden name

IDA DEHAVEN

15. Birthplace

MARYLAND

16. Informant

MRS. CORA S. GROVE

Address

POTOMAC PARK RT. #6 - Cumberland

17.

BURIAL
(Burial, cremation, or removal, Which?)

Date thereof

JULY 3, 1948
(month) (day) (year)

Cemetery or crematory

SALISBURY - PA. 1906

Location

SALISBURY - PA.

18. Funeral director

Address

Stanley W. Thomas
Salisbury Pa

19.

June 30 1948
(Date rec'd by registrar)

1948

W.F. Trout, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 30, 1948 19 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

May 1, 1948 to June 30, 1948
and that I last saw him alive on June 30, 1948

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 6:30-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5735

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumtberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 80-1-10
 Hospital, institution, or street address where death occurred
535 Fayette St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumtberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 535 Fayette St
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

John Hammond

3. (b) Social Security Number

None.

4. Sex Male 5. Color of face White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife B. Gray Shryock
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) May 18 1868
 8. AGE: Years 80 Months 1 Days 10 If less than one day hrs. min.

9. Birthplace Cumtberland Ind.
 (Town, county, and state)

10. Usual occupation Snip

11. Industry or business Cemetery

12. Name Andrew Hammond

13. Birthplace Germany

14. Maiden name Eva Beckwith

15. Birthplace Germany

16. Informant Mrs. Gray S. Hammond

Address Cumtberland

17. Burial Date thereof July 1 48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cem
 Location Cumtberland

18. Funeral director Louis Stein Inc

Address Cumtberland
 19. June 30 48 W. R. Nantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19. 48 at 5:45 P.
 21. I CERTIFY that death occurred on the date above stated—that I attended deceased from Jan 1 48 to June 28 48
 and that I last saw him alive on June 28 48
 Immediate cause of death

Chronic myocarditis 2 yrs
Arterial Hypertension 2 yrs
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Nature of injury Injured at work?

23. SIGNATURE R. W. Truaskie, M.D.
Cumtberland Ind M. D. or other
 Date signed 6/28/48

RECEIVED

JUL 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Ann Haverstick

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Graff Haverstick

7. Birth date of deceased (mo., day, yr.)

June 30, 1865

6. (c) If alive, give age

74 years

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>11</u>	<u>15</u>	<u>hrs. min.</u>

9. Birthplace

Vale Summit Allegany, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

12. Name

Anthony Sharpe

13. Birthplace

Germany

14. Maiden name

Catherine Tife

15. Birthplace

Germany

16. Informant

William Jones

Address

Frostburg Md.

17. Burial, cremation, or removal (Which?)

BurialDate thereof June 17, 1948

Cemetery or crematory

Allegany Cemetery

Location

Frostburg Md.

18. Funeral director

J. R. Grist

Address

Frostburg Md.19. 6-17 1948
(Date rec'd by registrar)Mr. Harry N. Roe
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. Bowery St.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 7, 1948 to June 14, 1948and that I last saw her alive on June 14, 1948

Immediate cause of death

Coronary heart disease

DURATION

1 wk

Due to

Hypertension

Due to

Heart Block

Other conditions

Heart Block

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W. M. Lane MD
M. D. or otherAddress Frostburg Md. Date signed 6-15-48

RECEIVED

JUN 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Miners Hospital
 How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 157 Wood St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Hayes

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Charles W. Hayes
 7. Birth date of deceased (mo., day, yr.) March 10, 1864 6.(c) If alive, give age years
 8. AGE: Years 84 Months 2 Days 28 If less than one day hrs. min.

9. Birthplace Germany
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business home
 12. Name Daniel Hammert
 13. Birthplace Germany
 14. Maiden name Elizabeth Hammert
 15. Birthplace Germany

16. Informant Walter Hayes
 Address Frostburg, Md.
 17. Burial (Burial, cremation, or removal. Which?) Burial Date interred June 10, 1948
 (month) (day) (year)
 Cemetery or crematory Allegany Cemetery
 Location Frostburg, Md.
 18. Funeral director J. R. Hurst
 Address Frostburg, Md.
 19. 6-10 19 48 Wm. Hawley H. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 48 at 8:45 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19 June 7 19 48
 and that I last saw him alive on June 7 19 48
 Immediate cause of death arteriosclerosis
 Due to Parkinson Syndrome
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Wm. Hawley H. Roe M. D. or other
 Address Frostburg, Md. Date signed 6-8-48

RECEIVED

JUN 14 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5738

10

1. PLACE OF DEATH:

County Allegheny
City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Francis Hergatt4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Laura B. Hergattdeceased 6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) March 30, 18588. AGE: Years 90 Months 2 Days 26 If less than one day hrs. min.9. Birthplace Mt. Savage Md.
(Town, county and state)10. Usual occupation retired machinist11. Industry or business C. & P. Shops12. Name Harry Hergatt13. Birthplace Germany14. Maiden name Rachel Lottig15. Birthplace Germany16. Informant Mrs. Oliver B. HergattAddress Corriganville Md.17. Burial Date thereof June 29, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. George's CemeteryLocation Mt. Savage Md.18. Funeral director J. R. ReistAddress Frostburg Md.19. June 29, 48 Veronica M. Sermutt
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Corriganville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2. (a) If veteran, name war

3. (b) Social Security Number

712-18-9343

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1948 at 6:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1948 to June 27, 1948and that I last saw him alive on June 17, 1948Immediate cause of death Exhaustion & Senility DURATIONDue to Fall May 27 injuryright hipDue to fractureright hipOther conditions

(Include pregnancy within 3 months of death)

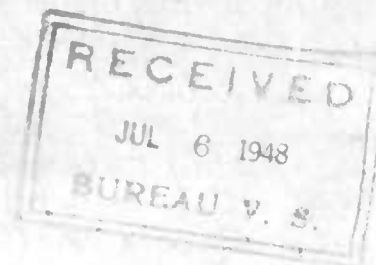
Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Self Killing Date of May 27 48Where did injury occur? Corriganville Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Fall from wall Injured at work? 23. SIGNATURE F. Alan G. Murray M. D. or other 45Address Corriganville Date signed June 28

PLEASE WRITE PLAINLY, WITHOUT UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
Cumberland
 City or town 47 Years
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Allegany Hospital
21 Days
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 226 Columbia Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Richard P. Hilleary

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Ida May Cassen Hilleary
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 14 1864
 8. AGE: Years 83 Months 8 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Piedmont, Mineral Co, West Virginia
 (Town, county, and state)
 10. Usual occupation News Stand
 11. Industry or business Selling Papers
 12. Name William A. Hilleary
 13. Birthplace Frederick, Md.
 14. Maiden name Samantha Vickroy
 15. Birthplace Centerville, Pa.

16. Informant Harry C. Hilleary
 Address 57 N. Centre St, Cumberland, Md.
 17. Burial Date thereof 6/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Cumberland, Md.
 Location
 18. Funeral director William H. Kight
 Address Cumberland, Md.

19. June 26, 1948 W. H. Kight, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 19 48 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 19 48 to June 24 19 48
 and that I last saw him alive on June 24 19 48
 Immediate cause of death Uremia

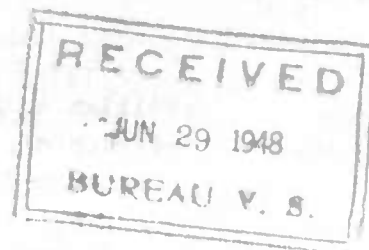
DURATION 6 wks
 Due to Arteriosclerotic Cardio-Vascular
renal disease
 Due to
 Other conditions Debility due to above

(Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE R. W. Hewas, Jr. M.D.
 Address Cumberland Date signed June 25



Within corporate limits *Louis Brigg*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *4*

1. PLACE OF DEATH:

County *Allegany*City or town *Cumberland*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *20 Minutes*Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Allegany*City or town *Rural Cumberland*
(If outside city or town limits, write RURAL and give nearest town)Street No. *R.D. # 6, Bowling Green*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Dennis Huddle

3. (b) Social Security Number

*214-07-6726*4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Anne Hammond Huddle*7. Birth date of deceased (mo., day, yr.) *Jan. 11, 1899* 6. (c) If alive, give age *42* years8. AGE: Years *49* Months *4* Days *29* If less than one day
hrs. min.9. Birthplace *Elkton, Va.*
(Town, county, and state)10. Usual occupation *Textile Engineering*11. Industry or business *Celanese Corp. Of America*12. Name *John T. Huddle*13. Birthplace *Elkton, Va.*14. Maiden name *Sallie Stockdell*15. Birthplace *Gordonsville, Va.*16. Informant *Mrs. Anne Huddle*Address *R.D. # 6 Cumberland, Md.*17. Burial Date thereof *June 13, 1948*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Hillcrest Burial Park*Location *Cumberland, Md.*18. Funeral director *Charles L. George*Address *Cumberland, Md.*19. *June 13, 1948* Registrar *W.R. Trout M.D.*

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 10, 1948* at *2:00 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 9, 1948* to *June 10, 1948*
and that I last saw him alive on *June 10, 1948*Immediate cause of death *acute coronary occlusion* DURATION *5 minutes*Due to *coronary sclerosis* *2 months*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results *complete coronary occlusion*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *L. H. Hines M.D.*Address *59 Green* Date signed *6-11-48*

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEATH NO.

DATE OF DEATH

RECEIVED
JUN 22 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830

5741

Reg. Dist. No. 4

1. PLACE OF DEATH:
 County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs
 Hospital, institution, or street address where death occurred:
403 Pennsylvania Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State W. Va County Preston
 City or town Newburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME Mrs Ida Jane Huffman 3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Charles H. Huffman
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 7, 1871

8. AGE: Years 77 Months 0 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Belleville, Preston Co. W. Va.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Peter Wolfe

13. Birthplace Preston Co. W. Va

14. Maiden name Louisa Sydwell

15. Birthplace Preston Co. W. Va

16. Informant Mrs Dacie Cox

Address 138 Semour St Cumb. Md

17. Burial Date thereof June 23, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory First Zion Methodist Cemetery

Location Marquess W. Va

18. Funeral director John J. Hooper

Address Cumberland, Md

19. June 21, 1948 W. H. Nantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 48 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 47, to June 20 19 48, and that I last saw her alive on June 20 19 48.

Immediate cause of death Cerebral Hemorrhage DURATION One year

Due to Arteriosclerosis Five years

Due to Chronic Hypertension Four years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Meane of injury _____ Injured at work?

23. SIGNATURE W. H. Nantz, M.D. M. D. or other _____
 Address Cumberland Md Date signed 6-21-48

RECEIVED

JUN 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. I will correct age if especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5742 159 9

1. PLACE OF DEATH:

County AlleganyCity or town Freshburg, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 dayHospital, institution, or street address where death occurred: Mines HospitalHow long in hospital or institution? 1 day

3. (a) FULL NAME

4. Sex Boy5. Color or race white6. (a) Single, married, widowed, or divorced Infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 31st, 19488. AGE: Years Months Days ☒ If less than one day
.....hrs.min.9. Birthplace Barton, Allegany, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Sherman S. Hyde13. Birthplace Barton, Md.14. Maiden name Ruby Shigins15. Birthplace Barton, Md.16. Informant Mr. Carson F. HydeAddress Barton, Md.17. Burial Date thereof 6-3-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Laurel HillLocation Morgantown, Md.18. Funeral director Gayle D. DyerAddress Freshburg, Md.19. 6-5 19 48 Mr. Nancy V. Rae
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Barton, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (c) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 19 48 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 31 19 48 to June 2 19 48and that I last saw him alive on June 2 19 48Immediate cause of death Premature

DURATION

7 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. E. Berry M. D.Address Piedmont, W. Va. Date signed 6/3/48

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5743

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

one day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 913 Frederick St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Antoinette Indolfi

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or

Salvatore Indolfi

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 11 1895

8. AGE:

Years

Months

Days

If less than one day

53

3

0

hrs.

min.

9. Birthplace

Rapallo, Italy
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

FATHER

12. Name

Angelo Albano

13. Birthplace

Italy

MOTHER

14. Maiden name

Josephine Russo

15. Birthplace

Italy

16. Informant

Rominick Indolfi

Address

913 Frederick St. Cumberland, Md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

June 14 1948
(month) (day) (year)

Cemetery or crematory

St Peter's & Paul's Cemetery

Location

Cumberland Md

18. Funeral director

Louis Stein, Inc.

Address

Cumberland Md.

19.

June 13, 1948
(Date rec'd by registrar)

W. L. Trautz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1948, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11 1948 to June 11 1948

and that I last saw her alive on

June 11 1948

Immediate cause of death

Myocarditis

DURATION

4 yrs.

Due to

Due to

Other conditions

Chronic nephritis 4 yrs
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

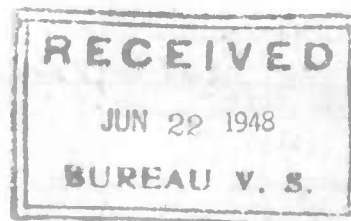
James T. Johnson, M.D.
Cumberland Md.
Date signed 6-11-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Johnson

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5744

Reg. Dist. No. 8

1. PLACE OF DEATH:

County... Allegany
 City or town... Pekin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 28 years
 Hospital, institution, or street address where death occurred:
own home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany
 City or town... Pekin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Henry Johnson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Louisa Harriet Johnson
 7. Birth date of deceased (mo., day, yr.) March 6, 1878 6.(c) If alive, give age 60 years
 8. AGE: Years 70 Months 3 Days 16 If less than one day
 hrs. min.

9. Birthplace Lanesburg, Allegany Co., Md.
(Town, county, and state)10. Usual occupation (Retired) Coal Miner11. Industry or business Campbell Coal Mine12. Name Johnson13. Birthplace unknown14. Maiden name Spiker15. Birthplace Scotland16. Informant Willis JohnsonAddress Pekin, Md.17. Burial Date thereof June 25, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Laurel Hill CemeteryLocation Moscow, Md.18. Funeral director W. E. JohnsonAddress Lanesburg, Md.19. June 25, 1948 Jannette M. Pool
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1948 at 4 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1948, to June 22, 1948and that I last saw him alive on June 22, 1948Immediate cause of death Acute myocarditis

DURATION

3 wks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE PE Berry M.D.Address Piedmont W. Va. Date signed 6/24/48

RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5745

93d

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Smithburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Walter C. Kennedy

3. (b) Social Security Number

214-07-0729

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Anna Kennedy

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 2 - 1882

8. AGE:

65

7

18

hrs. min.

9. Birthplace

Smithburg - Alleg - Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Elizabeth Kennedy

13. Birthplace

Elizabeth Whittease
W. Va.

14. Maiden name

15. Birthplace

16. Informant

Mrs. Walter Kennedy

Address

Smithburg, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 20, 1948
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

J. H. Dugan
Smithburg, Md.

19.

(Date rec'd by registrar)

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2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md.

County

allegany

City or town

Smithburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.

9 Stayer
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

20 June 1948

at

12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

20 June 1948

to 20 June 1948

and that I last saw him alive on

20 June 1948

Immediate cause of death

Congestive Heart Failure

DURATION

Due to

Hypertension
and atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

none done

Autopsy results

none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John B. Davis

M. D. another

Address

9 Stayer St

Date signed 27 June 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5746

50

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
313 Hammond St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 313 Hammond St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

ETTA VIRGINIA KERN

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Emmanuel M. Kern
 6. (c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) May 11, 1870
 8. AGE: Years 78 Months 1 Days 11 If less than one day hrs. min.

9. Birthplace Bedford, Bedford, Penna.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Own home

12. Name Henry C. Lashly
 13. Birthplace Penna.

14. Maiden name Not known

15. Birthplace

16. Informant Ma E. M. Kern
 Address 313 Hammond St, Westernport, Md.

17. Burial Date thereof June 26, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philos Cemetery
 Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal
 Address Westernport, Maryland

19. June 26 19. 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 (23) 1948 at 4:00 a.m.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 22 1948 and that I last saw him alive on 19

Immediate cause of death Carcinoma of breast with metastases to lungs. DURATION 14yr

Due to

Due to

Other conditions Pneumoconiosis (terminal) 1 day

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Thomas Reeves, M.D. M. D. or other
 Address Westernport Md. Date signed 6/28/48

RECEIVED

JUN 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5747

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY
 City or town... CUMBERLAND, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 DAY
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY
 City or town... CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 414 FRANKLIN ST.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

MR. JOHN F. KERNS

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED
 6. (b) Name of husband or wife HETTIE MORELAND
 7. Birth date of deceased (mo., day, yr.) APRIL 16, 1870 6. (c) If alive, give age 55 years
 8. AGE: Years 78 Months 2 Days 4 If less than one day
 hrs. min.

9. Birthplace WEST VIRGINIA
 (Town, county, and state)
 10. Usual occupation RETIRED B & O EMPLOYEE
 11. Industry or business

12. Name FREDERICK KERNS
 13. Birthplace VIRGINIA
 14. Maiden name HARTLEY, ELIZABETH
 15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
MEMORIAL AVE., CITY
 Address

17. Burial Date thereof June 21, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lebanon Cemetery
 Location Lebanon, W. Va.

18. Funeral director W. H. McFree
Augusta W. Va.
 Address

19. June 21, 1948 Walter R. Grant, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 20, 1948 3:14 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19, 1948 to June 20, 1948
 and that I last saw him alive on June 19, 1948

Immediate cause of death Hemiplegia DURATION 1 day

Due to arterio-sclerosis ?

Due to Chr. Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Wilson M. D. or other

Address Cumberland, Md. Date signed 6-20-48

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JUN 29 1948

BUREAU V. S.
RECEIVED

JUN 20 1948

BUREAU V. S.

Within corporate limits. DR. RANSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5748

159

1. PLACE OF DEATH:

County... alleganyCity or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 22 HRS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... GarrettCity or town... DEER PARK
(If outside city or town limits, write RURAL and give nearest town)Street No... DEER PARK MD
(If rural, give LOCATION)2.(a) If veteran, name war... ☒

3. (a) FULL NAME

KIMMELL BABY GIRL

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE NEW BORN

6.(b) Name of husband or wife

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) JUNE 28, 19488. AGE: Years Months Days If less than one day
22 hrs. min.9. Birthplace... Cumberland Allegany MD
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name... RUSSELL KIMMELL13. Birthplace... MARYLAND14. Maiden name... VIOLA BROADWATER15. Birthplace... MARYLAND16. Informant... MEMORIAL HOSPITALAddress... MEMORIAL AVE17. Cremation Date thereof... June 29 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Memorial HospitalLocation... Cumberland, Maryland18. Funeral director... As above

Address

19. June 29, 1948 W. F. Huntz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... JUNE 29 19 48 at 3:00 AM21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
28 June 1948 to 29 June 1948and that I last saw him alive on 28 June 1948Immediate cause of death... Respiratory failure DURATIONPrematurityDue to... wt 3lb 2oz

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

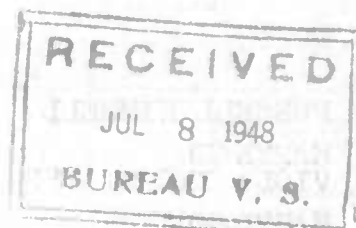
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Leland Ranson MDAddress... 41 Greene St. Cumberland 29 June 48

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Linnie B. Kirby

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Joseph P. Kirby

7. Birth date of deceased (mo., day, yr.)

Mar 28 - 18806. (c) If alive, give age 74 1/2 years

8. AGE:

Years

Months

Days

If less than one day

68213

hrs.

min.

9. Birthplace

MT Savage - ally - Md.
(Town, county, and state)

10. Usual occupation

house wife

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?)

Date thereof June 3 - 1948
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 6-12 1948
(Date rec'd by registrar)Mr. Naudy & Roe
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town MT Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. Main
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1948 at 7 p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1948 to June 10 1948
and that I last saw her alive on June 10 1948

Immediate cause of death

apoplectic coma
uremia

Due to

hypertension

Due to

chronic nephritis

Other conditions

diabetes

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. Wolferman M.D.

M. D. or other

Address 134 E Main & Frothingham Date signed 6-12-48

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JUN 14 1948

BUREAU V. S.

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date shown on:

FHM No. G 116 JUL

8 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5751

Reg. Dist. No. 19

1. PLACE OF DEATH

County Allegheny
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. 202 Frostburg, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank Jacob Lashbaugh

3. (b) Social Security Number

213-07-9874

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Minnie M. Eisel

7. Birth date of deceased (mo., day, yr.) April 29th 1888 8. (c) If alive, give age 58 years

8. AGE: Years 59 Month 1 Days 27 If less than one day hrs. min.

9. Birthplace Charles, Allegheny, Md.
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal Miner

12. Name George Lashbaugh

13. Birthplace Barton, Md.

14. Maiden name Elizabeth Paley

15. Birthplace Frostburg Co. Md.

16. Informant Mrs. Frank D. Dager

Address Box 195 Frostburg, Md.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof June 28-1948
(month) (day) (year)

Cemetery or crematory Allegheny

Location Frostburg, Md.

18. Funeral director James D. Dager

Address Frostburg, Md.

19. 6/29 19 48 Wm. R. Rice
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25 19 48 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 19 48 to June 25 19 48
and that I last saw him alive on June 25 19 48

Immediate cause of death Hemiplegic
paroxysmal hyperextension DURATION 1 day

Due to pulmonary tuberculosis
chronic nephritis ?

Due to Silicosis ?

Other conditions Silicosis ?

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

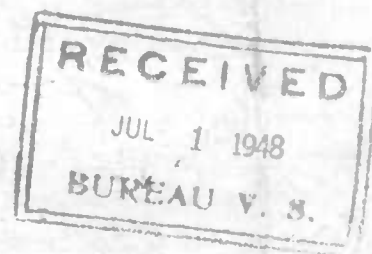
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Wolfenman M.D.
M. D. or other Frostburg

Address Frostburg Date signed 6-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1600

5752

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Crabtree
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 hr

Hospital, institution, or street address where death occurred:

Allegheny Hospital
1 hr

How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Oldtown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

HAROLD NILE Baby Lesnure

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

June 21 1948

8. AGE:

Years

Months

Days

If less than one day

1 hrs. 30 min.

9. Birthplace

Crabtree Ind.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER

12. Name

Wm Daniel Lesnure

13. Birthplace

Oldtown Ind.

MOTHER

14. Maiden name

Engenia Stehman

15. Birthplace

Oldtown Ind.

16. Informant

Wm Daniel Lesnure

Address

Oldtown Ind.

17.

BurialDate thereof 6-21-48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Old Olive Cem

Location

Oldtown Ind.

18. Funeral director

Louis Stein Inc

Address

Crabtree

19.

June 21 1948

(Date rec'd by registrar)

W. H. Laury, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 21 1948 to June 21 1948and that I last saw him alive on June 21 1948

Immediate cause of death

intercranial hemorrhage

DURATION

1 hour

Due to

birth injury

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

L. H. Laury, M.D.

M. D. or other

Address 59 Green St. Date signed 6-24-48

RECEIVED

JUN 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County **ALLEGANY**
 City or town **CUMBERLAND, MARYLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
MEMORIAL Hospital
 How long in hospital or institution? **9 HRS.**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State **WEST VA.** County **Preston**
 City or town **TERRA ALTA**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **RT. #8**
 (If rural, give LOCATION) ✓
 2.(a) if veteran, name war

3. (a) FULL NAME

ELLSWORTH LEWIS

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE**WHITE****Widowed**6. (b) Name of husband or wife **Flora Ann Bucklew Lewis**7. Birth date of deceased (mo., day, yr.) **October 17, 1871**8. AGE: Years Months Days If less than one day
76 8 12 hrs. min.9. Birthplace **W. VA. Hundred**
(Town, county, and state)10. Usual occupation **Trackman - Retired**11. Industry or business **Byrd & R.R. Co.**12. Name **Samuel Lewis**13. Birthplace **Hundred, W. Va.**14. Maiden name **Unknown**

15. Birthplace

16. Informant **MEMORIAL HOSPITAL**Address **CUMBERLAND, MD.**17. **Burial & Removal** Date thereof **June 29, 1948**
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory **Five Grove**Location **Near Terra Alta W. Va.**18. Funeral director **Fike - Western Fun Home**Address **Terra Alta W. Va.**19. **June 29, 1948** (Date rec'd by registrar) **W. H. Smith, M.D.** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **JUNE 29, 1948 10:35 A.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **6:29** to **6:29**, 19 **48**, and that I last saw him alive on **6:29**, 19 **48**Immediate cause of death **Chronic Nephritis (uremic)**Due to **Chronic Myocardial Degeneration**

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations **None**Date of op. **None**Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **W. H. Williams** M. D. or otherAddress **Cumberland** Date signed **June 29, 1948**

RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

124 N.Center St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 124 N.Center St.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

Mrs. Ethel B. Frantz Gunning Liles

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white widow6.(b) Name of husband or wife Charles V. Liles

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 18868. AGE: Years Months Days If less than one day
62 1 17 hrs. min.9. Birthplace Cumberland Md.
(Town, county, and state)10. Usual occupation House wife11. Industry or business Home12. Name Daniel Frantz13. Birthplace England14. Maiden name Flavilla Bowden15. Birthplace Unknown16. Informant Mr. Eugene GunningAddress Cumberland, Md.17. Burial June 30 1948

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rose Hill Cem.Location Cumberland, Md.18. Funeral director Louis Stein Inc.Address Cumberland, Md.19. June 30, 1948 W.R. Frantz, M.D.

(Date rec'd by registrar) Registrar

3.(b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 19 48 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. er Dead June 29 19 48

Immediate cause of death

Chronic (rheumatic) endocarditis

DURATION

severalyears

Due to

Due to

Other conditions arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.Address Cumberland Md. Date signed 6-29-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1948

BUREAU V. S.

Inside of
city limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Alleghany
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
enroute to Dr. Murray's home, Little Mt.
How long in hospital or institution? no answer death there

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Alleghany
City or town Corriganville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name War _____

3. (a) FULL NAME

Lawrence Mathias Logsdon

3. (b) Social Security Number

215-015-479

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Violet Kirchner

7. Birth date of deceased (mo., day, yr.)

Sep 5, 1903

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

4496

hrs.

min.

9. Birthplace

Corriganville Alleghany Md.
(Town, county, and state)

10. Usual occupation

Tire Worker

11. Industry or business

Rubber Mfg.

FATHER

12. Name

William L. Logsdon

13. Birthplace

Alleghany Co., Md.

MOTHER

14. Maiden name

Martha Everline

15. Birthplace

Somerset Co., Penna.

16. Informant

Violet Logsdon

Address

Corriganville, Md.

17.

Burial

Date thereof

June 14, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Wellersburg Ref. Church

Location

Wellersburg, Penna.

18. Funeral director

Harvey H. Zeigler

Address

Hyndman, Pa.

19.

June 14, 1948W. L. Trantz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1948 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 1948 to June 11, 1948 and that I last saw him alive on June 11, 1948

Immediate cause of death

Crown Thrombosis

DURATION

4 hrs

Due to

Coronary due to block

Due to

on death in auto accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

F. Alan G. Murray, M.D.

M. D. or other

Address

Cumberland Md.

Date signed

June 11

motor v. trans. ret. from Cam. M.V. - Dr. Maldeis advised that
the auto. acc. could not have caused the Coronary
Thrombosis. 8/9/48 G.S.

RECEIVED

JUN 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 68 Hill St
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

George Joseph Mallow

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1943

8. AGE: Years Months Days If less than one day
5 1 19 hrs. min.

9. Birthplace Frostburg Allegany, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Guy Mallow

13. Birthplace West Virginia

14. Maiden name Ruth Lancaster

15. Birthplace Maryland

16. Informant Guy Mallow

Address Frostburg Md

17. Burial Date thereof June 26, 1948
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md

18. Funeral director J. R. Hurst

Address Frostburg Md

19. 6/25 1948 Mrs. B. O. Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23 1948 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/20 1947 to 6/23 1948
and that I last saw him alive on 6/23 1948

Immediate cause of death Respiratory paralysis DURATION 10 min.

Due to Ether anesthesia for tonsillectomy (35 min. p. operation).

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Chronic hypertrophied infected tonsils + adenoids Date of op. 6/23/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank T. Harriet MD M. D. or other

Address 59 E. Main St. Frostburg Md. Date signed 6/25/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 28 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5757

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 HRS 45 MINUTES

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 5 HRS 45 MI

3. (a) FULL NAME (McELeish)
BBBY BOY McELEISH

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced INFANT

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JUNE 5, 1948

8. AGE: Years Months Days If less than one day 5 hrs. 45 min.

9. Birthplace CUMBERLAND, ALLEGANY, MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name WILLIAM McELEISH

13. Birthplace CUMBERLAND, MARYLAND

14. Maiden name JOAN MARY KERR

15. Birthplace NEW YORK CITY, NEW YORK

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE

17. BURIAL Date thereof JUNE 7, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HILLCREST CEMETERY

Location CUMBERLAND, MARYLAND

18. Funeral director JOHN J. HAFFER

Address CUMBERLAND, MARYLAND

19. June 7, 1948 W. F. Haugh M.D.
(Date rec'd by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 618 NIAGRA ST.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 5, 1948, at 9:00 AM

21. I CERTIFY that death occurred on the date above stated; that attended deceased from June 5, 1948, to June 5, 1948
and that I last saw him alive on June 5, 1948

Immediate cause of death Perinatal activity

DURATION

Due to Separated placenta

Due to

Other conditions Compound presentation - Vertex, right hand & foot.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Haugh, M.D.

Cumberland, Md M. D. or other

Address Date signed 6/5/48

DR HOOGE

RECEIVED

JUN 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

5758

Reg. Dist. No. 4

1. PLACE OF DEATH:

County allaganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color of face

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 25 1948

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

19 min.

9. Birthplace

Cumberland Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, (Where?))

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

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2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 25 1948 at 2:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 25 1948 to June 25 1948

and that I last saw him alive on June 25 1948

Immediate cause of death

Pneumonia, Biliary Stasis

DURATION

Due to

Enlarged Liver

Due to

Pneumonia on lungs

Other conditions

Enlarged Spleen

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed June 25 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5759

4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 years
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 8 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 210 1/2 Knox St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war 1st

3. (a) FULL NAME

Walter Daniel Mont

3. (b) Social Security Number

217-10-6489

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary C. Mansfield
 7. Birth date of deceased (mo., day, yr.) September 10, 1892
 6.(c) If alive, give age 51 years
 8. AGE: Years 55 Months 8 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Mt. Savage, Allegheny, Maryland
 (Town, county, and state)

10. Usual occupation Pipe Shop Foreman

11. Industry or business Kelly Springfield Tire Co.

12. Name Charles Walter Mont

13. Birthplace Halifax, Nova Scotia

14. Maiden name Louisa Dannelly

15. Birthplace Carlisle, England

16. Informant Mrs. Mary C. Mont

Address 210 1/2 Knox St. Cumberland, Md.

17. Burial Date thereof June 8, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location Mt. Savage, Maryland

18. Funeral director John J. Hager

Address Cumberland, Md.

19. June 8, 1948 W.R. Tautz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1948 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1948 to June 5, 1948
 and that I last saw him alive on June 5, 1948

Immediate cause of death

myocardial infarction
stroke

Due to

arteriosclerotic heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

JUN 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 70 Years
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 21 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 88 LaVale Blvd
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Alfred Northcraft

3. (b) Social Security Number

214-07-0770

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Clara Northcraft
 7. Birth date of deceased (mo., day, yr.) September 22 1873 6.(c) If alive, give age..... years
 8. AGE: Years 74 Months 9 Days 4 If less than one day..... hrs. min.

9. Birthplace Green Ridge, Md. Allegany Co
 (Town, county, and state)
 10. Usual occupation Guard
 11. Industry or business Kelly Springfield Tire Co
 12. Name Edward Northcraft
 13. Birthplace Green Ridge, Md.
 14. Maiden name Mary Roby
 15. Birthplace Green Ridge, Md.

16. Informant Micheal Northcraft
 Address Beryl, W. Va.
 17. Burial Date thereof 6/28/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Cumberland, Md.
 18. Funeral director William H. Kight
 Address Cumberland, Md.

19. June 28, 1948 W.D. Frank, D.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26 19 48 at 2:54 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/5 in 19 to 6/26 19 48
 and that I last saw him alive on 6/25 19 48

Immediate cause of death stroke at embolism DURATION 5 days
 Due to coronary occlusion 20 days
arteriosclerosis of heart
 Due to disease
 Other conditions arteriosclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury injured at work?

23. SIGNATURE Elizabeth Brown, M.D. M. D. or other
LaVale, Md. Date signed 6/26

P. Bump

RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5761

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3.1 years

Hospital, institution, or street address where death occurred:

Allegheny County InfirmaryHow long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 616 Sylvan Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Estella Pennington

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Phillip Pennington

5. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1881

8. AGE:

Years

Months

Days

If less than one day

6719

hrs.

min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name James H. Haller13. Birthplace South Hampton, England14. Maiden name Mary E. Hetz15. Birthplace Baltimore, Md.16. Informant Mr. L. L. FreeAddress 616 Sylvan Ave., Cumberland, Md.17. Burial Date thereof July 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore CemeteryLocation Baltimore, Maryland18. Funeral director John J. HughesAddress Cumberland, Md.19. July 4, 1948 W. L. Trout, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1948 at 10⁰⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 23, 1948 to June 30, 1948and that I last saw him alive on June 29, 1948

Immediate cause of death

Myocardial infarction

DURATION

9 daysDue to Arteriosclerotic hypertensive disease

Due to

6 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

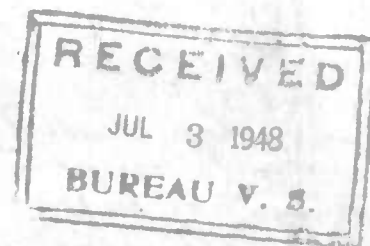
Injured at work?

23. SIGNATURE

Arthur F. Jones, Jr., M.D.

M. D. or other

Address 110 S. Centre St Date signed 7-1-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5762 8

1. PLACE OF DEATH:

County AlleganyCity or town Lonaconing Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Douglas Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Pekin
(If outside city or town limits, write RURAL and give nearest town)Street No. Douglas Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Elizabeth Ann Plaskett

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 - 18788. AGE: Years Months Days If less than one day
69 8 21 hrs. min.9. Birthplace Pekin, Allegany Co., Md
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own home12. Name William Plaskett13. Birthplace England14. Maiden name Elizabeth Black15. Birthplace England16. Informant Mrs. George W. MurdockAddress Lonaconing, Md.17. Burial Date thereof July 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Laurel Hill CemeteryLocation Moscow, Md18. Funeral director McEichhornAddress Lonaconing, Md.19. July 10 19 48 Janet M. Deal
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 48 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive Dead June 29 19 48

Immediate cause of death

Coronary occlusion due to DURATION at onceCoronary sclerosis

Due to

Due to

Other conditions Epileptic for 55 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or RegistrarAddress Cumberland Md. Date signed 6-29-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1948

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County **ALLEGANY**
 City or town **CUMBERLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **7 HRS 28 MI**
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? **7 HRS 28 MI**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **MARYLAND** County **ALLEGANY**
 City or town **CUMBERLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **476 BALTO. AVE**
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

PRICE BABY GIRL DONNA SUE

3. (b) Social Security Number

None

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, married, widowed, or divorced **NEWBORN**

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **JUNE 28, 1948** 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
7 hrs. **28** min.

9. Birthplace **Cumberland Allegany Co., Md.**
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name **JOHN PRICE**13. Birthplace **MARYLAND, Cumberland**14. Maiden name **NORMA JEAN McCALL**15. Birthplace **MARYLAND, Cumberland**16. Informant **MEMORIAL HOSPITAL**Address **MEMORIAL AVE.**

17. **Burial** Date thereof **6/30/48**
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory **Hill Crest Cemetery**Location **Cumberland, Md.**18. Funeral director **William H. Kight**Address **Cumberland, Md.**

June 30, 19 48 **W.R. Trout, M.D.**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **JUNE 29 19 48, at 3:30 A**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
28 June 19 48 to **29 June 19 48**
 and that I last saw him alive on **29 June 19 48**

Immediate cause of death **Prematurity (7 mo)** DURATION

Due to **Premature Separation**Due to **Placental**Other conditions **Hemorrhage**

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE **Julius B. Whitworth** M. D. or other
 Address **112 Bedford St.** Date signed **29 June 48**

RECEIVED

JUL 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5764

4

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 weeks
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany
 City or town Consolidation Frostburg Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

Mary K. Pairick

213-18-0935

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, & divorced Married

6.(b) Name of husband or wife Mary Schuster

7. Birth date of deceased (mo., day, yr.) May 13 - 1889 6.(c) If alive, give age 56 years

8. AGE: Years 59 Months 0 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Frostburg Allegany, Md.
(Town, county, and state)

10. Usual occupation Fuel Mfg Operator

11. Industry or business _____

12. Name Joseph L. Pairick

13. Birthplace Allegany Co. Md.

14. Maiden name E. Elizabeth Smith

15. Birthplace Frostburg, Md.

16. Informant Mrs. Elizabeth Inguarino

Address Consolidation Frostburg Md.

17. Burial Date thereof 6-8-48
(Burial, cremation, or removal. Write month (day) (year))

Cemetery or crematory St. Elizabeth's

Location St. Frostburg, Md.

18. Funeral director James J. Jones

Address Frostburg, Md.

19. June 7, 1948 W. L. Nantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1948 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1948 to June 5, 1948
 and that I last saw him alive on June 4, 1948

Immediate cause of death peritonitis DURATION 3 weeks

Due to appendicitis (ruptured)

Due to _____

Other conditions intestinal obstruction and multiple chronic pleuritis
(Include pregnancy within 3 months of death)

Major findings of operations ruptured sigmoid appendix, peritonitis Date of op. 5-17-48

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE (Klein) (M.D.)

M. D. or other _____

Address 59 Green St. Date signed 6-5-48

RECEIVED

JUN 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr P. R. Wilson

5765

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport - rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 66 years
 Hospital, institution, or street address where death occurred:
1 mile north of Westernport
 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Westernport - rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1 mile north of Westernport
 (If rural, give LOCATION)
 2.(a) If veteran, name war - - - - -

3. (a) FULL NAME

WALTER EDWARD RANDALLS

3. (b) Social Security Number

212-18-1389

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife - - - - -

7. Birth date of deceased (mo., day, yr.) May 7, 1882 6. (c) If alive, give age - - - years

8. AGE: Years 66 Months 1 Days 0 If less than one day - - - hrs. - - - min.

9. Birthplace Franklin, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation Laborer11. Industry or business Pulp mill12. Name David Randalls13. Birthplace West Virginia14. Maiden name Rebecca Carver15. Birthplace Virginia16. Informant Mrs Pansy BlackburnAddress Westernport, Md.

17. Burial Date thereof June 10, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Philos CemeteryLocation Westernport, Md.18. Funeral director Ellsworth S. BoalAddress Westernport, Maryland

19. June 10 19 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1948 19 48 at 10:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 19 48 to June 7 19 48

and that I last saw him alive on June 7 19 48

Immediate cause of death Chronic Myocarditis
and Myocardial Degeneration
Not specified as Rheumatic DURATION 1 Year
 Due to - - - - -

Due to - - - - -

Other conditions Pulmonary Edema 1 Day

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. - - - - -Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
 Accident, suicide, or homicide - - - - - Date of - - - - -

Where did injury occur? - - - - - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) - - - - -Means of injury - - - - - Injured at work? - - - - -

23. SIGNATURE Paul R. Wilson, M.D.
 M. D. or other - - - - -

Address Piedmont, W.V. Date signed June 9, 1948

RECEIVED

JUN 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5767

938

4

1. PLACE OF DEATH:

County Allegheny
City or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68-10-16
Hospital, institution, or street address where death occurred: Allegheny Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 500 Hilltop Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

John L. Reed

3. (b) Social Security Number

714-05-6466

4. Sex Male 5. Color White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary E. Reed

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1879

8. AGE: Years 68 Months 10 Days 16 If less than one day hrs. min.

9. Birthplace Cumtland Ind
(Town, county, and state)

10. Usual occupation Cafe & Restaurant

11. Industry or business Proprietor

12. Name James Reed

13. Birthplace Ind

14. Maiden name Elizabeth Blundering

15. Birthplace England

16. Informant Mrs Mary E Reed

Address Cumtland

17. Smile Date thereof June 15 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Marys Burial Park

Location New Cumtland Ind

18. Funeral director Louis Stein Inc

Address Cumtland

19. June 14 48 W. H. Fantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 48 at 12:20 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 48 to June 12 19 48

and that I last saw him alive on June 12 19 48

Immediate cause of death acute pulmonary congestion -

Due to chronic myocarditis

Due to

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James E. Reed M.D.

Address 49 Green St. Date signed 6.14.48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1948

BUREAU V. S.

RECEIVED

JUN 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5769

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 75-8-16

Hospital, institution, or street address where death occurred:

Allegheny Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 875 1st Royal Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elle May Reinhart

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1872

8. AGE:

Years

Months

Days

If less than one day

75816

hrs.

min.

9. Birthplace

Cumberland Ind
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

at Home

FATHER

12. Name

Francis Reinhart

13. Birthplace

Ind

MOTHER

14. Maiden name

Mary A Downey

15. Birthplace

Ind

16. Informant

Wm Reinhart

Address

Cumberland

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

June 27 48

(month) (day) (year)

Cemetery or crematory

St Peter & Pauls

Location

Cumberland

18. Funeral director

Homo Stern Inc

Address

Cumberland

19. Date rec'd by registry

June 16, 1948W.R. Jantz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1948 at 7 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Dec. 1947 to 15 June 1948 and that I last saw him alive on 14 June 48 1948

Immediate cause of death

Cerebral Hemorrhage with
it. sample

DURATION

4 day

Due to

Hypertensive Vascular

Due to

excess

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Alfred Van Cleave

M. D. or other

Address

Cumberland, Md.Date signed 15 June 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5770

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Days
 Hospital, institution, or street address where death occurred:
519 Linden St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W.Va. County Hampshire
 City or town Greenspring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Mary Margaret Robison

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife George W. Robison
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 2 1870
 8. AGE: Years 78 Months 4 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace North Branch, Md Allegany County
 (Town, county, and state)

10. Usual occupation House

11. Industry or business _____

FATHER 12. Name William W. Teeters

13. Birthplace Holidaysburg Pa

MOTHER 14. Maiden name Hannah Monett

15. Birthplace North Branch, Md

16. Informant Charles W. Robison

Address 519 Linden St, Cumberland, Md.

17. Burial Date thereof 6/15/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dans Run Cemetery

Location Ft Ashby, W. Va.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. June 14 19 48 W. H. Kight, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13th 19 48 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 19 48 to 6-13 19 48
 and that I last saw her alive on 6-10-48 19 48

Immediate cause of death Stroke following fracture of hip (M.D.)

Due to fall

Due to _____

Other conditions osteoporosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-7-48

Where did injury occur? Greenspring Pa (City or town) W.Va (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury fall Injured at work? No

23. SIGNATURE J. Romney M.D.

Address Romney Date signed 13 June 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The attest age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Age
One year
5 days
113 Lincoln St

any person

Place of death
Boston, Mass.

RECEIVED
JUN 22 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5771

13a

Reg. Dist. No. 9

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Mumers Hospital
 How long in hospital or institution?..... 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Allegany
 City or town..... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 91 Bowers St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William Rodda

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.)

October 28, 1869

6. (c) If alive, give age..... years

8. AGE:

78715

If less than one day

hrs.

min.

9. Birthplace

England
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

shoe repair shop

MOTHER FATHER

12. Name

William Rodda

13. Birthplace

England

14. Maiden name

Mary Hicks

15. Birthplace

England

16. Informant

Miss Eva Rodda

Address

Frostburg Md.

17.

Burial
(Burial, cremation, or removal. Which?)Date of death..... June 16, 1948
(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg Md.

18. Funeral director

J. R. Hurst

Address

Frostburg Md.

19.

6-16
(Date rec'd by registrar)

19.

48 Mrs. Adey H. Roe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 13, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 19..... to June 13, 1948and that I last saw him alive on June 12, 1948

Immediate cause of death

Pericarditis
anemia

DURATION

3 yrs

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE

W. M. Lane MD

M. D. or other

Address..... Frostburg Md. Date signed 6-14-48

RECEIVED

JUN 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5772

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 218 COLUMBIA STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

ROHRER, WILLIAM D. MR.

3.(b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

WEBSTER, MARY Clairbelle Stuck

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

APRIL 23, 1873

8. AGE:

Years

Months

Days

If less than one day

75125

hrs.

min.

9. Birthplace

MARYLAND, Cumberland
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER
MOTHER12. Name ROHRER, LORENZO13. Birthplace Keedysville, Md.14. Maiden name Catherine Webster15. Birthplace Md.

16. Informant

George L. RohrerAddress 218 Columbia St., Cumberland, Md

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof June 22, 1948
(month) (day) (year)Cemetery or crematory Keedysville CemeteryLocation Keedysville, Md.

18. Funeral director

John J. HefnerAddress Cumbersville, Maryland

19.

June 21, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 18, 1948 at 2:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1948 to June 18, 1948and that I last saw him alive on 6-18-48Immediate cause of death Chronic nephritis

DURATION

?

Due to

Due to

Other conditions arteriosclerosis
bronchogenic carcinoma
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE Howard J. Tolson, M.D.Address Cumbersville, Md. Date signed 6-18-48

RECEIVED
JUN 29 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5773

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
City or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Yrs
Hospital, institution, or street address where death occurred:
Cresaptown, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No. World War 1
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Reginald (None) Rollings

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife Lula Smith

6. (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1880

8. AGE: Years 67 Months 5 Days 21 If less than one day hrs. min.

9. Birthplace England
(Town, county, and state)

10. Usual occupation Retired Mill Worker

11. Industry or business

12. Name James Rollings
13. Birthplace England
Charlotte Haddock

14. Maiden name

15. Birthplace England

16. Informant Mrs. Chester A. Wolfe

Address Cresaptown, Md.
Burial

17. Date thereof June 15, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md.

18. Funeral director John T. Wolford

Address 125 S Liberty

19. June 15-48 M. J. Kuntz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1948 at 11 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct-12 1947 to June 12 1948
and that I last saw him alive on June 12 1948

Immediate cause of death Bi. Lobal Pulmonary TB.
Tuberculous enteritis

Due to

Due to

Other conditions Rheumatoid Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm H. McFarland M.D.

Address Cresaptown Date signed June 14-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1948

BUREAU V. S.

Within corporate limits
Dr. Weisburger

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

5774

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Rt. # 6
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs.
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 1/2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town near Cumberland Rt. # 6 Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 33 Narrows Park
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Helen Ella "Williams" Rosley

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Albert A. Rosley

7. Birth date of deceased (mo., day, yr.)

October 15, 18956. (c) If alive, give age 63 years

8. AGE:

52 Years7 Months16 Days

If less than one day

hrs. min.

9. Birthplace

Radnoke Radnoke, Virginia
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Own home

MOTHER FATHER

12. Name

George Williams

13. Birthplace

Unknown

14. Maiden name

Georgia Unknown

15. Birthplace

?

16. Informant

Mr. Albert A. Rosley

Address

Rt # 6 Cumberland, Md.

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

June 4, 1948
(month) (day) (year)

Cemetery or crematory

Hill Crest Cemetery

Location

Cumberland, Md.

19. Funeral director

John J. Hafer

Address

Cumberland, Md.

19.

June 4, 1948W.R. Fautz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1948 at 10:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May June 31, 1948 to June 1, 1948and that I last saw her alive on June 1, 1948Immediate cause of death Hemo-pericardiumdue to dissecting
aneurysm of aortaDue to Idiopathic necrosis
of the aortaOther conditions Aortic atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Beversmay

M. D. or other

Address 122 Bedford St, Cumberland Date signed 6/3/48

PLEASE WRITE PLAINLY, UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Non-syphilitic - 8/2/48

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

5765

93d

1. PLACE OF DEATH:

County Allegany
City or town Franklin, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 38 years
Hospital, institution, or street address where death occurred:
98 W. Pleasant St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD. County Allegany
City or town Franklin, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 98 W. Pleasant
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Vincent Smith Reckley

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Margaret Reckley

7. Birth date of deceased (mo., day, yr.) June 11th, 1864 6. (c) If alive, give age 78 years

8. AGE: Years 83 Months 5 Days 20 If less than one day hrs. min.

9. Birthplace Franklin, Allegany, Md.
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name John Jacob Reckley

13. Birthplace Franklin, Md.

14. Maiden name Josephine J. J. J.

15. Birthplace Franklin, Md.

16. Informant Mrs. Lillian Berens

Address 98 W. Pleasant St. Franklin, Md.

17. Burial Date thereof June 4-1948
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Franklin, Md.

18. Funeral director James H. Baker

Address Franklin, Md.

19. 6-3 48 Mr. Nancy A. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1948 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to June 1, 1948

and that I last saw him alive on May 31, 1948

Immediate cause of death acute pyelitis

Due to hypertension DURATION 2 weeks

Due to myocarditis several years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE WOM Line M. D. or other

Address Franklin, Md. Date signed June 2, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 7 1948

BUREAU V. 8.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

5775

93d

1. PLACE OF DEATH:

County AlleganyCity or town Eckhart Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Albert C. Sandvik

3. (b) Social Security Number

213-09-6518

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Catherine F. Hess Sandvik

7. Birth date of deceased (mo., day, yr.)

May 26-18916. (c) If alive, give age 55 years

8. AGE:

Years

Months

Days

If less than one day

5713

hrs.

min.

9. Birthplace Eckhart Md.
(Town, county, and state)10. Usual occupation retired-coalminer

11. Industry or business

FATHER

12. Name Andrew Sandvik13. Birthplace Norway

MOTHER

14. Maiden name Catherine Eisentrout15. Birthplace Norway16. Informant Catherine F. Hess (wife.)Address Eckhart Md.17. burial Date thereof July 2, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Allegany Cemetery,Location Frostburg, Md.18. Funeral director J. R. Durst,Address Frostburg, Md.19. 7-1 48 Mr. Hancey X. Roe
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 48 at 11.50 ^P_M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to 19 48and that I last saw him alive Dead June 30 19 48

Immediate cause of death

Chronic myocarditis with
hypertrophy

DURATION

6

years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

Deputy Medical Examiner - Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. _____Address Cumberland Md. Date signed 6-30-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 3 1948/
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Alleghany
 City or town Vale Summit
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Alleghany
 City or town Vale Summit
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Annie B. Schiller

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) June 29, 1865
 8. AGE: Years 82 Months 11 Days 12 It less than one day
 hrs. min.

9. Birthplace Glenco Somerset Co., Pa.
 (Town, county, and state)
 10. Usual occupation Housekeeper
 11. Industry or business Domestic
 12. Name John C. Schiller
 13. Birthplace Pa.
 14. Maiden name Anna Margaret Weindold
 15. Birthplace Pa.

16. Informant William Schiller
 Address Vale Summit, Md.
 17. Burial Date thereof June 12, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Johnsburg
 Location South Hampton Twp., Somerset Co., Penna.
 18. Funeral director Harvey H. Zeigler
 Address Hyndman, Pa.

19. 6-11 48 Ms Nancy N. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1948 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10 June 1948 to 10 June 1948
 and that I last saw him alive on 9 June 1948

Immediate cause of death Cerebral Hemorrhage DURATION

Due to Hypertension & Coronary Disease

Due to Enlargement

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results none done Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John B. Davis M. D. or other

Address Throbbing, Md. Date signed 11 June 48

RECEIVED

JUN 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Cumberland,
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 yrs.
 Hospital, institution, or street address where death occurred:
 861 Gephart Drive
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Allegany
 City or town..... Cumberland,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 861 Gephart Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

JENNIE LEE SHERWOOD

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Edwin A. Sherwood

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1869
 6.(c) If alive, give age..... years

8. AGE: Years 79 Months 5 Days 15 If less than one day
 hrs. min.

9. Birthplace Booneville, Mo.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Rennison
 13. Birthplace Unknown

14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Mrs. H. C. Rainalter
 Address 861 Gephart Drive, Cumberland,

17. Burial Date thereof July 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elmwood Cem.
 Location Kansas City, Mo.

18. Funeral director H. Wayne George
 Address Cumberland, Md.

19. June 26, 1948 W.R. Tandy, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1948 at 7:02 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-9-1948 to June 25, 1948 and that I last saw her alive on June 23, 1948

Immediate cause of death Chronic nephritis (chronic)
 Due to Chronic myocardial degeneration
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations. None Date of op. none

Autopsy results. None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury Injured at work?

23. SIGNATURE W.F. Williams M.D. or other
 Address Cumberland Date signed 6-26-48

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUN 20 1948

BUREAU V. S.

1

Within corporate limits
Dr. R. Brings

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

5778

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hosp.
How long in hospital or institution? 33 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 219 Paca St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES L. SIMPSON

3. (b) Social Security Number

705-09-7492

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Ida A. Anderson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1878

8. AGE: Years 69 Months 6 Days 2 It less than one day
hrs. min.

9. Birthplace Horse Shoe, W. Va.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business B. & O. Railroad

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Walter Nazelrod

Address 111 Lennox Place Cumberland

17. Burial Date thereof June 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion Cem.

Location Near Keyser W. Va.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. June 26, 48 Chas. Frank, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about 3 to June 25 and that I last saw him alive on June 25

Immediate cause of death congestive heart failure DURATION 4 months

Due to chronic atherosclerosis heart disease 20 years

Due to

Other conditions chronic hypoxemia 20 years

(Include pregnancy within 8 months of death)

Major findings of operation

Autopsy results congestive heart failure

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Brings M.D. M. D. or other

Address 59 S. E. St. Date signed 6-26-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

RECEIVED

JUN 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
115 mt. Pleasant St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 115 mt. Pleasant St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Francis Sleeman

3. (b) Social Security Number

214-07-1124

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Helene Sleeman

7. Birth date of deceased (mo., day, yr.)

May 11, 1879

6. (c) If alive, give age

68 years

8. AGE:

Years

Months

Days

If less than one day

69114

hrs.

min.

9. Birthplace

Vale Summit Allegany, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

Kelly Springfield Tire Co.

MOTHER FATHER

12. Name

John I. Sleeman

13. Birthplace

England

14. Maiden name

Annebella Watkins

15. Birthplace

unknown

16. Informant

Veronica Sleeman

Address

Frostburg Md.

17.

Burial, cremation, or removal, Which?

Burial

Date of death

June 25-48
(month) (day) (year)

Cemetery or crematory

St. Michael's Cemetery

Location

Frostburg Md.

18. Funeral director

Address

J. R. Diest
Frostburg Md.

19.

June 25 - 1948

(To be read by registrar)

Thos. W. Price
Acting

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 221948, at 1301 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945

19

to June 221948

and that I last saw him alive on

June 211948

Immediate cause of death

acute Cardiac dilatation

DURATION

2 hrs

Due to

Chc Myocarditis6 mo

Due to

arterio sclerosisseveral years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

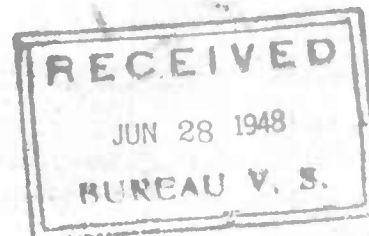
23. SIGNATURE

W. M. Lane MD

M. D. or other

Address

Frostburg Md.Date signed 6-23-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 5780 9

1. PLACE OF DEATH:

County Allegheny
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Allegheny
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4 Stager St.
(If rural, give LOCATION)
2. (a) If veteran, name was

3. (a) FULL NAME

Thomas Smith

3. (b) Social Security Number

396-01-8460

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Onnie Hayes Smith

7. Birth date of deceased (mo., day, yr.)

Jan. 22 - 1888

6. (c) If alive, give age

67 years

8. AGE:

Years

Months

Days

If less than one day

60

4

27

hrs.

min.

9. Birthplace

New York, N.Y.
(Town, County, and state)

10. Usual occupation

Shovel Operator

11. Industry or business

Strip Mining Co.

FATHER
MOTHER

12. Name

Alexander Smith

13. Birthplace

New York, N.Y.

14. Maiden name

Mary Holmes

15. Birthplace

New York, N.Y.

16. Informant

Mrs. Thomas Smith

Address

4 Stager St. Frostburg, Md.

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

6-31-1948
(month) (day) (year)

Cemetery or crematory

Allegheny Cemetery

Location

Frostburg, Md.

18. Funeral director

James D. Price

Address

Frostburg, Md.

19.

6/21
(Date rec'd by registrar)

19 48

James D. Price
acting Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 18 19 48 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 22 19 48 to June 18 19 48

and that I last saw him alive on June 18 19 48.

Immediate cause of death

Carcinoma of Stomach

DURATION

7 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J.C. Diehl, M.D.

M. D. or other

Address Frostburg, Md. Date signed 6/21/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County, Allegany
 City or town, Eckhart
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Isabel S. Sparks

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Ernest A. Sparks

7. Birth date of deceased (mo., day, yr.)

May 31, 1872

6. (c) If alive, age years

8. AGE:

Years

Months

Days

It less than one day

76029

hrs.

min.

9. Birthplace

Mellows Mills

(Town, county, and State)

Md.

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

William J. Saloway

13. Birthplace

Maryland

14. Maiden name

Hannah Stott

15. Birthplace

Maryland

16. Informant

Leroy Sparks

Address

Eckhart Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

July 2, 1948

Cemetery or crematory

Crompton Cemetery

Location

Crompton Md.

18. Funeral director

Louis Stein Inc

Address

Cumberland Md.

19. 6-30

(Date rec'd by registrar)

19

48 Mrs. Nancy N. Bae

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State, Maryland County, AlleganyCity or town, Eckhart
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

E.S.T.

20. DATE OF DEATH June 29 1948 at 10:25P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947 to June 29 1948and that I last saw her alive on June 22 1948Immediate cause of death Teasing of R. HipSpRAIN R. HipDue to St. HemiplegiaDue to hypertensionOther conditions CholesterolOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosisOther conditions arteriosclerosis

RECEIVED

JUL 2 1948

BUREAU V. S.

Dr. Dick Wills

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93c

5782

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 years
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 421 Baltimore Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mabel Wilson Spencer

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ellis Spencer

7. Birth date of deceased (mo., day, yr.)

September 12, 19236. (c) If alive, give age 35 years

8. AGE:

24 Years8 Months10 Days

If less than one day

hrs. min.

9. Birthplace

Cumberland, Allegheny, Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

12. Name

Levi Wilson

13. Birthplace

?

14. Maiden name

Agnes Winebrenner

15. Birthplace

?

16. Informant

Ellis Spencer

Address

421 Balto Ave., Cumberland, Md
Borival

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

June 5, 1948

Cemetery or crematory

Allegheny Cemetery

Location

Frostburg, Maryland

18. Funeral director

John J. Hoffer

Address

Cumberland, Md.

19. Date rec'd by registrar

June 5, 1948W.R. Fautz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2/48 19. at 10 am21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/15/48 19. to 6/2/48 19.and that I last saw him alive on 6/2/48 19.

Immediate cause of death

Myocardial infarction

DURATION

3 days

Due to

Rheumatic fever

Due to

Staphylococcal endocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. Vegetation on valves - PetechiaeAutopsy results Vegetation on valves - Petechiae
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W.R. Fautz, M.D.
Address Cumberland, Md. Date signed 6/4/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5791

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 DAY
Hospital, institution, or street address where death occurred:MEMORIAL HOSPITAL
How long in hospital or institution 1 day2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State MARYLAND County ALLEGANY
City or town CUMBERLAND Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

BABY GIRL STOUFFER, BARBARA ANN

3. (b) Social Security Number

None4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 6/7/48 6.(c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Allegany, Md.
(Town, county, and state)10. Usual occupation None

11. Industry or business _____

12. Name RAY STOUFFER13. Birthplace MARYLAND14. Maiden name WITTE, MARY E15. Birthplace MARYLAND16. Informant Ray StoufferAddress Cumberland Md.17. Burial Date thereof 6/18/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory MadleyLocation Hyndman, Pa.18. Funeral director Harvey H. LeylerAddress Hyndman, Pa.19. June 8 19 48 Wk. Hantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 48 at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 19 48 to June 7 19 48 and that I last saw him alive on June 7 19 48Immediate cause of death Adipososis DURATION 1 dayDue to permeability

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm H. McFarlane M. D. or other _____Address Cresaptown Md. Date signed 7-8-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Eastburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, y.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

48

Ms.

Haley

N. Roe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name War

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

JUN 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

DR. WILSON

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 DAYS

Hospital, institution or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 14 DAYS

3. (a) FULL NAME

Sarah TICE, CARLISTA

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife JOHN ANDREW TICEELK GARDEN, W. VA.7. Birth date of deceased (mo., day, yr.) October 17, 1872

8. AGE:

75

Years

Months

Days

If less than one day

720

hrs.

min.

9. Birthplace WEST VIRGINIA, ELK GARDEN
(Town, county, and state)10. Usual occupation WIFE

11. Industry or business

12. Name ANDREW SKILLINGHURST13. Birthplace WEST VIRGINIA14. Maiden name EVANS, ANNA15. Birthplace WEST VIRGINIA16. Informant Memorial Hosp.
Cumberland, Md.17. Burial Date thereof June 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory I. O. O. F. CemLocation Elk Garden, W. Va.18. Funeral director Rogers Funeral HomeAddress Rogers, W. Va.19. June 7, 1948 W. R. Frantz, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERALCity or town ELK GARDEN
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1948 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4, 1948 to June 7, 1948
and that I last saw him June 7, 1948 alive on _____

Immediate cause of death _____

DURATION

Due to Ectopic sarcoma4 M.O.R.?Due to Ectopic sarcoma

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Ectopic sarcoma retroperitoneal Date of op. 5-25-48

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE F. M. Hargis M. D. or otherAddress Cumberland, Md. Date signed 6-7-48

RECEIVED

JUN 15 1948

BUREAU V. S.

DR FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 43 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County alleganyCity or town near CUMBERLAND, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. RT # 3 VALLEY RD

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MR. WILMER VANPELT4. Sex MALE5. Color or race WHITE6.(a) Single, married, widowed, or divorced DIVORCED6.(b) Name of husband or wife THELMA LEPLY6.(c) If alive, give age 39 years7. Birth date of deceased (mo., day, yr.) OCT 20, 19068. AGE: Years 41 Months 7 Days 15 If less than one day hrs. min.9. Birthplace VIRGINIA Harrisonburg

(Town, county, and state)

10. Usual occupation None Truck Driver11. Industry or business Japanese Corp.12. Name VAN PELT, CHARLES13. Birthplace VIRGINIA MARGARET14. Maiden name MARGARET Sowers15. Birthplace VIRGINIA16. Informant MEMORIAL HOSPITALAddress MEMORIAL AVENUE17. Burial Date thereof 6/8/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory Fountain CemeteryLocation Keyser, W. Va.18. Funeral director William H. KightAddress Cumberland, Md.

19. June 7, 1948 W.R. Trautz, M.D. Registrar

(Date rec'd by registrar)

3. (b) Social Security Number

214-27-1949

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 5 19 48 at 11:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June April 23, 1948 to June 5, 1948 and that I last saw him alive on June 5, 1948Immediate cause of death Chronic glomerular - nephritis
hypertension
hypertensive heart
disease

DURATION

8 yrs.8 yrs.Due to terminal uremia April 23, 1948

Other condition

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) No

Means of injury Injured at work?

23. SIGNATURE W.R. Trautz, M.D.

M.D. or other

Address 5 Washington St. Court Date signed June 5, 1948

Address Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Dawson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 weeks
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State W. Va. County Mineral
 City or town Keyser
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 35 North Church St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No ✓

3. (a) FULL NAME

Walter Clinton Whistler

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widower</u>	
6. (b) Name of husband or wife <u>Edna Jane (Davis) Whistler</u>			
7. Birth date of deceased (mo., day, yr.) <u>Jan. 1880</u>			
6. (c) If alive, give age _____ years			
8. AGE: Years <u>68</u>	Months	Days	If less than one day _____ hrs. _____ min.
9. Birthplace <u>Broaway, Va.</u> (Town, county, and state)			
10. Usual occupation <u>El. Engineer B. & O. Ry. Co.</u> (Retired)			
11. Industry or business			
12. Name <u>Samuel Robert Whistler</u>			
13. Birthplace <u>Virginia</u>			
14. Maiden name <u>Frances Rebecca Todd</u>			
15. Birthplace <u>Ohio</u>			

16. Informant <u>Mrs. Wm. S. Caldwell</u>	
Address <u>Keyser, W. Va.</u>	
17. Burial	Date thereof <u>June 22, 1948</u>
(Burial, cremation, or removal. Which?)	(month) (day) (year)
Cemetery or crematory <u>xxx, Queens Point</u>	
Location <u>Keyser, W. Va.</u>	
18. Funeral director <u>B. H. McKeown</u>	
Address <u>Keyser, W. Va.</u>	

19. June 22 19 48 W. H. McKeown
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 48, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1948 to June 20, 1948
 and that I last saw him alive on June 19, 1948

Immediate cause of death Coronary thrombosis

Due to acute arteriosclerosis

Due to _____

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. McKeown M. D. or otherAddress Keyser, W. Va. Date signed 6-21-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 58 years

Hospital, institution, or street address where death occurred:

Fayette St. St. Peter and Paul Monastery

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street Fayette Street - Monastery
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Rev. Fr. Benedict Joseph Wich

3.(b) Social Security Number

None

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

January 24, 1866

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

8247hrs.min.

9. Birthplace

Pittsburgh, Penna.
(Town, county, and state)

10. Usual occupation

Priest

11. Industry or business

Roman Catholic Church

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Informant

Address

18. Informant

Address

19. Informant

Address

20. Informant

Address

21. Informant

Address

22. Informant

Address

23. Informant

Address

24. Informant

Address

25. Informant

Address

26. Informant

Address

27. Informant

Address

28. Informant

Address

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1948 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/1/48 to 6/1/48and that I last saw him alive on 5/31/48

Immediate cause of death

chronic myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 6/1/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

(Date rec'd by registrar)

Registrar

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5788

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
MEMORIAL Hospital
How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND Pa County COUNTY Somerset
City or town CUMBERLAND, Somerset
(If outside city or town limits, write RURAL and give nearest town)
Street No. West Union St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME

MARGUERITE F. WINTERS.

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE
6.(b) Name of husband or wife
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) July 5, 1872
8. AGE: Years 75 Months 11 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace PENNA
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home

12. Name JOHN WINTERS
13. Birthplace PENNA.

14. Maiden name JANE BOWMAN
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial Date thereof June 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Husband Cemetery
Location Somerset, Pa.

18. Funeral director Walter S. Hoffman
Address 138 E. Main St., Somerset, Pa.

19. June 23, 1948 W.R. Hantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1948
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-22-48 to 6-23-48
and that I last saw him alive on 6-23-48

Immediate cause of death Adenocarcinoma of sigmoid with lymph node metastases
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations Same as above
Date of op. 9-3-47
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Wm. F. Williams
Address Cumberland Date signed 6-23-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 29 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159 5789

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 HOURS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 8 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. OLDTOWN ROAD - R. F. D. #4
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

WOLFE, BABY BOY SAMMY LEE

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JUNE 2, 1948 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
17 hrs. 15 min.

9. Birthplace Near Cumberland, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name WOLFE, JAMES

13. Birthplace WEST VIRGINIA

14. Maiden name LEWIS, LUCY

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address MEMORIAL AVE., CITY

17. Burial Date thereof June 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mr. Haman Cemetery
Location Road, Cumberland, Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. June 4, 1948 Registrar Walter R. Prater, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 2, 1948 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1948 to June 2, 1948 and that I last saw him alive on June 2, 1948

Immediate cause of death Premature
Cardiovascular failure

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter R. Prater, M.D.

Address 122 Bedford St. Cumberland, Md. Date signed 6/4/48

RECEIVED

JUN 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The least age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date shown on:

FILM No. G 116 JUN 22 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

5790

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

76 W. 200 St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 76 W. 200 St.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Margaret Youngerman

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Conrad Youngerman

7. Birth date of deceased (mo., day, yr.)

Jan. 22nd, 1858

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

90

6

19

hrs.

min.

9. Birthplace

Frostburg, Allegany, Md.
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

Wm. Schell

13. Birthplace

Germany

14. Maiden name

Elizabeth Roeder

15. Birthplace

Germany

16. Informant

Address

Mrs. Frank Oppen

76 W. 200 Frostburg, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Aug 15, 1948
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

Allegany

Frostburg, Md.

James W. Bae

19.

6-15-48
(Date rec'd by registrar)

James W. Bae
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19 48 at 3:34 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1948 19 June 13 19 48

and that I last saw him alive on June 10 19 48

Immediate cause of death

Old myocarditis

DURATION

many years

Due to

Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. June MD
Address Frostburg Md Date signed 6-14-48

RECEIVED

JUN 18 1948

BUREAU V. S.